



**Maternal and Child Health Services  
Title V Block Grant**

**State Narrative for  
Wisconsin**

**Application for 2013  
Annual Report for 2011**



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## **I. General Requirements**

### **A. Letter of Transmittal**

The Letter of Transmittal is to be provided as an attachment to this section.

***An attachment is included in this section. 1A - Letter of Transmittal***

### **B. Face Sheet**

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

### **C. Assurances and Certifications**

ASSURANCES & CERTIFICATIONS Attached

***An attachment is included in this section. 1C - Assurances and Certifications***

### **D. Table of Contents**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

### **E. Public Input**

In Wisconsin, the opportunity for public input into the Title V planning process has been ongoing, utilizing a variety of methods at both the state and local levels. These methods have included placement of the majority of the MCH Block Grant Application on the Department of Health Services' web page to make it available for public review and input; extending a formal request for input from the Maternal & Child Health Advisory Committee, the Birth Defects Council, the Newborn Screening Umbrella Committee, local health departments, and statewide projects that receive MCH funding as well as any interested stakeholders in the spring of each year, and establishing an on-line survey tool and dedicated email address DHSDPHMCH@wisconsin.gov to gather responses. In addition, Family Voices of WI conducts a listening session every year at the Circles of Life Conference for families of children and youth with special health care needs to determine the strengths and areas for growth in the current structure of services available. Informally, individual MCH staff receive input from partners in writing via email or verbally via face to face conversations or telephone throughout the year.

As part of ongoing quality improvement processes undertaken by the MCH/CYSHCN Programs while planning for the upcoming five year block grant cycle for 2011-2015, improving public input was identified as an area to strengthen. Three specific action steps toward this goal have been taken in anticipation of the 2011 application including:

1. Expanded membership of the MCH Advisory Committee to include a greater number of MCH and CYSHCN partners, including parents with close to 100 invited participants. These participants represent a wide variety of stakeholders, including staff from reproductive health, newborn screening, oral health and injury & violence prevention programs as well as other DHS Programs, Departments of Public Instruction and Children and Families, and local health departments. Some of the partners and agencies participating included the Regional CYSHCN Centers; WI Coalition Against Sexual Assault; Great Lakes Inter-Tribal Council; WI Association of Perinatal Care; WI Family Ties; Family Voices of WI; UW School of Medicine and Public Health; Children's Service Society of WI; Children's Hospital of WI; UW Waisman Center -- LEND Program and Clinical Services; Infant Death Center of WI; Family Planning Health Services; Black Health Coalition of WI; WI Alliance for Women's Health; March of Dimes; Disability Rights

WI; First Breath Program; and Mental Health America of WI.

2. Focused utilization of the expanded MCH Advisory Committee in the identification of values to guide the needs assessment process, identification of needs of the maternal and child health populations, the development of issue maps and approval of strategies to guide the direction of the MCH Program over the next five year cycle, especially identifying where collective resources could result in better outcomes for women and children in the state.

3. Conducted an evaluation process based on the participatory research model to identify methods to improve the understanding of and input received from the MCH Advisory Committee members and partners in future years.

These activities resulted in greater numbers of people providing meaningful input in the development of the 2011 Application and a plan to strengthen the public input process for future applications. It is anticipated in future years that public input will be received through at least the following:

- a formal all-day MCH Advisory Committee Block Grant review to be held annually;
- the development of an Executive Summary of the MCH Block Grant;
- the development of specific questions to be answered by the public based on review of the Executive Summary; and
- the sharing of excerpts of the application on-line for review throughout the year by key partners and stakeholders.

//2012/ The online tool was restructured to focus on major and emerging health concerns and unmet needs for the target populations served by the block grant. In addition, the tool asked for input on the service delivery system for these populations, to include what is and is not working well. The tool generated 161 responses which expressed overwhelming support for prevention-related services. The following issues were addressed in the comments: strong support for access to and funding for reproductive health services; supports for families with newborns; developmental screening and early identification services; parenting education and supports; adequate and appropriate nutrition/obesity prevention; mental health screening and services; oral health; and support systems and services for the undocumented. //2012//

***//2013/ The issues addressed via the online tool were a reiteration of what was shared in 2012, in particular strong support for reproductive health services. Others things mentioned were: breastfeeding education and support, childhood obesity, and supports for families who have a child with special health care needs. It was suggested the MCH Program continue to find ways to further collaboration and integration with the DPH accreditation work at both the State and with LHDs and QI project opportunities as part of that process. //2013//***

## **II. Needs Assessment**

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

### **C. Needs Assessment Summary**

For the 2010 needs assessment process, the vision of WI's Title V leaders was to involve the community of interest and stakeholders in a data driven process to bridge the needs of women, infants, children, including children with special health care needs and families and the strategies for their solution. The WI Title V Program embraced the unique opportunity the needs assessment provided to implement statewide results-based accountability strategies to improve the health of the MCH populations. As such, the needs assessment was approached as the essential first step of a larger comprehensive strategic planning effort identifying priorities and providing a roadmap for guiding local and state public health activities to address the priorities identified during the 5-year phase of the Title V MCH Block Grant.

Consideration was given to multiple factors in selecting WI's priorities including findings from a review of MCH related data trends and data analysis; local health department input; statewide projects and funded organizations input; MCH Advisory Committee issue mapping and analysis; capacity assessment of the Family Health Section (FHS); and ongoing input from the FHS staff, DPH administration, Regional and LPHD staff and other partners around the state.

The priorities of the Wisconsin Title V Program for 2011-2015 are:

- a) Reduce health disparities for women, infants, and children, including those with special health care needs.
- b) Increase the number of women, children, and families who receive preventive and treatment health services within a medical home.
- c) Increase the number of children and youth with special health care needs and their families who access necessary services and supports.
- d) Increase the number of women, men, and families who have knowledge of and skills to promote optimal infant and child health, development, and growth.
- e) Increase the number of women, children, and families who have optimal mental health and healthy relationships.
- f) Increase the number of women, men, and families who have knowledge of and skills to promote optimal reproductive health and pregnancy planning.
- g) Increase the number of women, children, and families who receive preventive screenings, early identification, and intervention.
- h) Increase the number of women, children, and families who live in a safe and healthy community.

The eight priorities align with the DHS State Health Plan, Healthiest Wisconsin 2020 and the Bureau of Community Health Promotion's mission to have Healthy People at Every Stage of Life. The Connecting the Dots document makes the link between the MCH priorities, National Performance Measures, State Performance Measures, related Outcomes and Health Status Indicators and measurements identified in Healthiest Wisconsin 2020. See Attachment II.C1. - Connecting the Dots

The priorities relate to the Life Course Framework, providing the base to support and implement interventions that target factors as early as possible and acknowledging the role of families, systems and communities to support protective factors and reduce risk factors that influence the health of individuals and populations. The scope of the priorities for 2011-2015 is broad and can only be addressed through work undertaken in collaboration with a variety of internal and external partners.

To address the priorities identified in the Needs Assessment, the MCH Program made significant changes to MCH funded activities within local public health departments in WI. Prior to the 2010 needs assessment, MCH funds to local agencies were used for many individual services. Beginning in 2011, local MCH activities support early childhood systems approaches to have a greater impact on MCH priorities and outcomes identified by Title V as well as Healthiest WI 2020. 2011 was a transition year and half of the LPHDs elected to begin participating in this work. In 2012, all LPHDs use MCH funds to support one or both of the following initiatives: 1) The Wisconsin Healthiest Families strive to assure all families have supports focused on family supports, child development, mental health &/or safety and injury prevention and 2) Keeping Kids Alive strives to establish a sustainable, coordinated system to identify causes of all fetal, infant and child deaths, resulting in preventive strategies for community action. System-building activities include collaborating with community partners to progress through steps of assessment, planning, implementation/evaluation and sustainability/quality improvement. Core competencies were developed based on the MCH Leadership Competencies to support this work. Included is a competency to demonstrate a working understanding of the Life Course Model. LHDs are expected to provide training on the Life Course Framework for their community partners. The MCH program is planning a TA request to MCHB for assistance from UW Population Health to evaluate this work.

In an effort to establish ongoing methods to evaluate progress on National and State Performance Measures and other required data elements, data from multiple years has been reviewed to identify progress and slippage. See Attachment II.C2. - Healthy People at Every Stage of Life.

Statewide and local activities to address the MCH priorities will continue into 2013. A review of internal and external stakeholder input, capacity of the MCH Program, and key MCH indicator data affirmed the priorities are still valid and no changes are needed as they still accurately reflect the needs of Wisconsin's MCH population. The priorities continue to provide a strong foundation for the current services and activities of the MCH Program and its partners and will continue to support improved outcomes for the MCH population.

Data on adverse childhood experiences (ACE) further supports a life course approach to address the MCH priorities in WI. Epidemiological research links adults' reports of adverse childhood experiences (ACEs) to their current physical and mental health, substance abuse, and other outcomes. The original ACE Study, conducted from 1995-1997, was the first large-scale study of the correlation between ACEs and negative adult health outcomes. Among the primarily middle-class, white, well-educated population studied in California, ACEs were linked to an increased risk of unhealthy behaviors such as smoking and alcohol use, chronic disease, impaired mental health, disability, and premature death.

As part of the 2010 WI Behavioral Risk Factor Survey (BRFS), more than 4,000 randomly selected WI adults were asked about adverse experiences, or ACEs, they may have had prior to age 18. BRFS results, weighted by CDC statistical staff, are representative of Wisconsin adults living in households with landline telephones.

WI's ACE results confirm that ACEs have a serious impact on the adult well-being of our state's residents. In the areas of mental health, physical health, health risk behaviors, socioeconomic status, and quality of life, WI adults with higher ACE scores have poorer outcomes. ACEs were found to be common among WI residents, with 56 % of the adult population having experienced at least one ACE. Sixteen percent of WI adults have an ACE score of 4 or higher. ACEs also tend to occur in clusters, such that people who experienced at least one ACE probably experienced multiple ACEs in childhood. WI residents with higher ACE scores were less likely to finish high school than those without ACE, had lower household income, and were three times more likely to be enrolled in Medicaid. All documented outcomes of ACE have also been shown to negatively impact pregnancy. Policy recommendations in the "Adverse Childhood Experiences

in WI: Findings from the 2010 Behavioral Risk Factor Survey" (January, 2012) work with the health care community to increase assessment and response to ACEs, including the Medicaid Program. See ([www.wichildrenstrustfund.org](http://www.wichildrenstrustfund.org)).

In a report on WI data from SPHERE documenting MCH/Medicaid Prenatal Care Coordination Services, 19% responded positively to the question "Have you ever been physically, sexually, verbally, or emotionally abused by a partner or someone close to you?" Women who were abused had 2-3 times higher rates of smoking and alcohol use before, during and after pregnancy, and being depressed and having high levels of stress both prenatally and postpartum than women not reporting abuse. Racial disparities in experiences of violence are reported in PRAMS, with highest rates among Black women in all categories, followed by Hispanic, Other, and White.

***An attachment is included in this section. IIC - Needs Assessment Summary***

### **III. State Overview**

#### **A. Overview**

##### **HEALTHIEST WISCONSIN 2020**

DHS is required by WI Statute 250.07 to develop a state public health agenda at least every 10 years. Planning for Healthiest WI 2020 (HW2020) began in 2008 and was completed in 2010. The collaborative process involves a 54-member Strategic Leadership Team appointed by the DHS Secretary, 23 Focus Area Strategic Teams and Support Teams, and Community Engagement Forums with direct links to the WI Public Health Council and the WI Minority Health Leadership Council.

The plan is grounded in science, measurement, strategic planning, quality assurance, and collaborative leadership that engage partners and promote shared responsibility and accountability across sectors. The vision for HW2020 is Everyone Living Better Longer. The overarching goals are to improve health across the lifespan and achieve health equity.

Two or more measurable objectives have been identified for each of 23 Focus Areas for HW2020.

Overarching Focus Areas: 1) Social, economic, and educational factors, and 2) Health disparities\*.

Infrastructure Focus Areas: 1) Access to quality health services\*, 2) Collaborative partnerships for community health improvement\*, 3) Diverse, sufficient, competent workforce that promotes and protects health\*, 4) Emergency preparedness, response and recovery, 5) Equitable, adequate, stable public health funding, 6) Health literacy and health education\*, 7) Public health capacity and quality, 8) Public health research and evaluation\*, and 9) Systems to manage and share health information and knowledge.

Health Focus Areas: 1) Adequate, appropriate, and safe food and nutrition, 2) Chronic disease prevention and management, 3) Communicable disease prevention and control, 4) Environmental and occupational health\*, 5) Healthy growth and development\*, 6) Mental health, 7) Oral health\*, 8) Physical activity, 9) Reproductive and sexual health\*, 10) Tobacco use and exposure, 11) Unhealthy alcohol and drug use, and 12) Violence and injury prevention\*.

Ten pillar objectives address overarching and recurring themes: 1) Comprehensive data to track health disparities, 2) Resources to eliminate health disparities, 3) Policies to reduce discrimination and increase social cohesion, 4) Policies to reduce poverty, 5) Policies to improve education, 6) Improved and connected health service system, 7) Youth and families prepared to protect health, 8) Environments that foster health and social networks, 9) Capability to evaluate the effectiveness and health impact of policies and programs, and 10) Resources for governmental public health infrastructure.

The Title V Program has had significant input into HW2020. There is representation on the Strategic Leadership Team with input to identify the 23 focus areas representing the factors influencing the health of the public. The Title V Program advocated for the state health plan to reflect a life course approach, acknowledging the health impact of early life events and critical developmental periods as well as the wear and tear a person experiences over time. Title V staff facilitated, recorded and provided TA to support the work of 11 of the 23 Focus Area Strategic Teams including Healthy Growth and Development, Reproductive and Sexual Health, Violence and Injury Prevention, Health Disparities and others identified by an asterisk in the list above.

This work involved defining the focus area, reviewing related data, identifying key objectives, measures and rationale, and identifying science-based strategies to meet the objective.

Objectives for select focus areas were also identified for the Children and Youth with Special Health Care Needs population on advice from the Title V Program.

/2012/ HW2020 Implementation Plan: 2010-2013 was developed in the fall of 2010 by the WI DHS in partnership with the Ad Hoc HW2020 Implementation Planning Team and with guidance from WI's public health system partners, including the MCH Program. The Implementation Plan identifies the strategic actions needed during the first three years of the decade to create the groundwork for achieving the goals and objectives identified in WI's State Health Plan. The Implementation Plan focuses on identifying action steps for the four components of implementation: 1) engaging partners and adopting objectives from HW2020; 2) assuring effective actions and results; 3) monitoring and reporting progress; and 4) linking actions specific to the HW2020 Focus Areas with the Pillar Objectives. The MCH Program is taking a leadership position to stimulate engagement, share leadership, establish accountability and garner the investment of agencies, including nontraditional stakeholders, as well as align systems and sectors to improve the health of the women, children and families of WI. //2012//

***/2013/ "Tracking a Decade's Progress: Summary Data for Healthiest WI 2010," was released 01/12. There were 91 total indicators for HW2010 health priority objectives with 48 (53%) showing improvement over the decade. Baseline data for the measures related to the HW2020 objectives are being collected and integrated into the WI Minority Health Program report. The MCH Program identified baseline data related to Healthy Growth and Development, Injury and Violence, Reproductive and Sexual Health and other focus areas with disability falling under the Disparity overarching focus area. //2013//***

#### PROGRAM INTEGRATION

DPH has a 10 year plus history of advocating program integration. MCH has been an active partner since the beginning. The current DPH Program Integration Workgroup is co-chaired by MCH staff. Two years ago the life course perspective was adopted and included the development of the Healthy People at Every Stage of Life framework that incorporated 6 key messages as defined by the Bureau of Community Health Staff: Plan Ahead, Eat Well, Be Active, Breathe Well, Be Safe, and Achieve Mental Wellness. The Family Health Section (FHS) has fully incorporated this framework and the supporting key messages across all of the program areas (Healthy People at Every Stage of Life Framework).

In addition to the internal efforts, WI is one of 6 states currently participating in a CDC Chronic Disease 3-year pilot (01/2009 to 12/2011) to help develop the future of chronic disease programming. While MCH is not an official component of the pilot, WI has incorporated MCH staff as part of the pilot leadership team with the intent of normalizing program integration across the Bureau. This approach fits with the life course perspective given that many chronic conditions share common risk factors (e.g., smoking, poor diet, lack of exercise) and by utilizing our "collective effort" we can reduce duplicative efforts and maximize efficiency of program resources. In order to have a true impact in wellness and health promotion we have to take an upstream approach and include the maternal and child health population.

/2012/ No changes. //2012//

***/2013/ Program Integration continues as a bureau directed effort and is transitioning direction to allow for alignment with the WI Prevention and Health Promotion plan. The MCH population is being captured in the development of this chronic disease integration plan. //2013//***

#### ELIMINATING RACIAL AND ETHNIC DISPARITIES IN BIRTH OUTCOMES

Eliminating racial and ethnic disparities in birth outcomes has been identified as one of the highest priorities for WI. In the recently released, HW2020, the elimination of health disparities is

1 of 3 overarching focus areas. A new objective, to reduce racial and ethnic disparities in poor birth outcomes by 2020, including infant mortality, has been created.

In 2008, 501 WI infants died during the first year of life. Of these, 315 were white and 100 were African American. The white infant mortality rate of 5.9 deaths/1,000 live births in WI was above the national Healthy People 2010 objective of 4.5 deaths/1,000 live births. Infant mortality rates for WI's racial/ethnic minority populations were much further from this objective; the African American infant mortality rate in 2006-2008 was 15.2.

During the past 20 years, infants born to WI African American women have been 3-4 times more likely to die within the first year of life than infants born to white women. Further, during the past 20 years, no sustained decline has occurred in WI's African American infant mortality rate. If African American infant mortality were reduced to the white infant mortality level, 57 of the 100 deaths would have been prevented. Compared to white infant mortality, disparities also exist among American Indian, Laotian, Hmong, and Hispanic/Latina populations, although disparities are smaller than those for African Americans.

Compared to other reporting states and the District of Columbia, WI's infant mortality ranking has worsened since 1979-1981. In 1979-1981, WI had the third best African American infant mortality rate (a rank of 3 among the 33 reporting states and the District of Columbia). In 2003-2005, WI had the third worst African American infant mortality rate, with at rank of 38 out of 39 reporting states and the District of Columbia. WI's rank based on white infant mortality rates also worsened relative to other states, moving from a rank of 5 in 1979-1981 to 13 in 2003-2005. WI's white infant mortality rate improved during the past two decades, but the improvement did not keep pace with other states.

In response to these startling statistics, WI established a statewide initiative to eliminate racial and ethnic disparities in birth outcomes. The following is an outline of the major highlights and components of this initiative:

#### Awareness and Promotion

- 2003--Statewide Summit: WI prioritizes racial and ethnic disparities in birth outcomes--MCH Program, other state and local MCH advocates sponsor event with national expert Dr. Michael Lu of UCLA presented life-course perspective on reducing disparities in birth outcomes; Healthy Babies regional action teams supported by Title V funds, and subsequent summits have been held, co-sponsored by March of Dimes and the Assoc. of Women's Health, Obstetric and Neonatal Nurses; Title V Program identifies a 1 FTE, Director of Disparities in Birth Outcomes (Patrice Onheiber)
- 2004--Milwaukee Forum: DHS/DPH host Milwaukee forum on Racial and Ethnic Disparities in Birth Outcomes with Mayor Barrett, Secretary Nelson, and Medicaid Program and expands focus of the issue to include Racine, Kenosha, and Beloit
- 2006--HRSA Community Strategic Partnership Review: HRSA brings together key partners to select infant mortality as the key population-based health indicator for collaborative state and local efforts in Milwaukee
- 2006 and ongoing--Statewide Advisory Committee on Eliminating Racial and Ethnic Disparities in Birth Outcomes: established to advise the DHS in the implementation of the initiative's Framework for Action and held town hall meetings to raise awareness, monitor progress, and promote best practices; established workgroups on communication and outreach, data, evidence-based practices, and policy and funding; committee meets 2 times/year; website provides list of participating organizations (<http://dhs.wisconsin.gov/healthybirths>)
- 2007--UW Partnership Funds: State Health Officer and MCH Chief Medical Officer deliver presentation in April to the WI Partnership Fund of the UW School of Medicine and Public Health; Dean Robert Golden reports to UW Regents in May that the school is willing to make a multi-year resource commitment to address the issue
- 2008-2009--Focus Groups and Social Marketing: begin community-driven social marketing

efforts with state Minority Health Program funds and federal funds; national experts brought on to technical advisory group

- 2008 and ongoing--DHS Performance Measure: eliminating racial and ethnic disparities in birth outcomes selected as a department-wide performance measure and a DPH priority initiative that is tracked and monitored
- 2009--A Response to the Crisis of Infant Mortality: Recommendations of the Statewide Advisory Committee on Eliminating Racial and Ethnic Disparities in Birth Outcomes released in July 2009 (<http://dhs.wisconsin.gov/healthybirths/advisory.htm>)
- 2009 and ongoing--Journey of a Lifetime Campaign: DHS Secretary Timberlake launches campaign in Milwaukee and Racine; ABCs for Healthy Families and campaign are presented at MCHB Partnership meeting in Washington DC, Delaware conference, and National WIC Association conference
- 2010 and ongoing--text4baby: DPH, Title V, and ABCs for Healthy Families join National Healthy Mothers Health Babies Coalition to promote text4 baby messages for pregnant and new moms
- 2010--Legislative Study on Infant Mortality: a Legislative Council Study on Infant Mortality has been proposed, as the result of a legislative briefing on eliminating racial and ethnic disparities in birth outcomes, organized by Rep. Cory Mason of Racine at Wingspread in January 2010
- 2010--Legislative Study on Strengthening Families: a Legislative Council study will in its final year of appointment focus on early brain development co-chaired by Sen. Lena Taylor and Rep. Steve Kestell

#### State and Federal Funds

- 2005--Home Visiting in Milwaukee: DPH awards \$4.5 million, 5-year TANF home visiting program to City of Milwaukee Health Dept; by 2007, program demonstrating positive birth outcomes in 6-central city zip code area; program expanded to additional zip codes
- 2007 and ongoing--Home visiting in Racine: 2007 WI Act 20 authorizes \$500,000 of GPR each biennium to reduce fetal and infant mortality and morbidity in Racine--ongoing TA provided
- 2008-2010--ABCs for Healthy Families: DHS receives \$498,000 from HRSA/MCHB for First Time Motherhood-First New Parents Initiative, 2-year federal social marketing grant to reduce African American infant mortality in Milwaukee and Racine
- 2009 and ongoing--WI Partnership Funds: UW School of Medicine and Public Health announces \$10 million, 5-year Lifecourse Initiative for Healthy Families (LIHF) to improve birth outcomes and reduce African American infant health disparities in Milwaukee, Racine, Kenosha, and Beloit

#### Statewide Collaborative Efforts

- 2003 and ongoing--Healthy Start: Title V staff participates on committees of Milwaukee Healthy Beginnings and Honoring our Children Healthy Start projects
- 2008 and ongoing--Medicaid: Title V staff collaborates with Medicaid to redesign Prenatal Care Coordination services and certification and provide recommendations for establishing a registry for high risk pregnant women
- 2009 and ongoing--WI Medical Home Pilot for Birth Outcomes: collaborate with Medicaid Program to establish a Medical Home Pilot and pay-for-performance benchmarks to reduce poor birth outcomes among high-risk pregnant women; implement evidence-based practices recommendations and provide information on mental health and social services referrals for the new Medicaid Managed Care Organizations in southeastern WI
- 2009 and ongoing--FIMR: Title V staff are working with the LHDs in Milwaukee, Racine, and Madison/ Dane County on continuing local or establishing regional FIMRs with plans to work with Rock County
- 2009 and ongoing--UW LIHF: Title V Chief Medical Officer and Southeastern Regional Office Deputy Director are steering committee members of UW LIHF; MCH staff, including Director of Disparities in Birth Outcomes, provide ongoing technical assistance
- 2009 and ongoing--Home Visiting: jointly plan with Dept of Children and Families for state and

federal home visiting services, including Empowering Families of Milwaukee at the City of Milwaukee Health Dept and Family Foundations home visiting services throughout the state

- 2009 and ongoing--Centering Pregnancy: DHS provided start-up funds for Centering Pregnancy prenatal care at Milwaukee Health Services and provide TA to other providers who want to promote it
- 2009-2010--Kellogg Action Learning Collaborative: support the Partnership to Eliminate Racial and Ethnic Disparities in Infant Mortality, action learning collaborative on racism and fatherhood in Milwaukee; ABCs for Healthy Families collaborate on messages for fathers
- 2009 and ongoing--PRAMS: use the Pregnancy Risk Assessment Monitoring System data to help inform MCH program priorities
- 2006 and ongoing--WI Minority Health Program: collaborate together and through HW2020 to improve birth outcomes for African American women
- 2008 and ongoing--WIC: support WIC efforts to increase breastfeeding and early enrollment for African American women participating in WIC; promote WIC services through Journey of a Lifetime campaign; presented the campaign at the National WIC conference in May 2010 in Milwaukee

See the extensive catalog of "Initiatives Addressing Disparities in Birth Outcomes in WI", compiled by the Center for Urban Population Health, April 2010 ([www.cuph.org](http://www.cuph.org))

/2012/ Preliminary 2009 data indicate similar trends in birth outcomes among all racial and ethnic groups in WI. The Milwaukee Journal Sentinel is featuring infant mortality in its "Empty Cradles" series for 2011, to "examine the problem and point to solutions" ([www.jsonline.com/news/119882229.html](http://www.jsonline.com/news/119882229.html)). New efforts for Title V include integrating the priority of eliminating racial and ethnic disparities in birth outcomes with development of the WI Healthiest Women's Initiative. //2012//

**/2013/ See HSI 8A-8B. //2013//**

#### American Recovery and Reinvestment Initiative

BCHP is a recipient of Federal stimulus dollars from the Prevention and Wellness Strategies funds totaling \$10,690,350 for the two year grant period February 2010 to 2012. WI received State Supplemental-State and Territories funding for 3 components related to reducing obesity by increasing physical activity and healthy eating and decreasing tobacco use with the following focus on policies: 1) Promote statewide policy and environmental changes that focus on health behaviors including 60 minutes of daily physical activity, farm to school nutrition, and compliance with smoke free work place laws, 2) Provide state level policy change in schools and child care settings, assuring 60 minutes of daily physical activity for youth 2-18, and 3) Expand/enhance tobacco cessation services through the Quit Line. WI also received Communities Putting Prevention to Work funds to implement evidence-based policy and environmental change that will reduce obesity and promote healthy living in LaCrosse and Wood Counties. Select strategies include: increasing the availability and accessibility of healthy foods such as farm to school programs, increasing safe routes to school and decreasing screen time. A goal of the BCHP is to create an organizational culture where program integration is the norm. This approach assures that the Title V MCH Program activities will be integrated with ARRA-funded activities related to nutrition, physical activity and tobacco control services.

**/2013/ Communities Putting Prevention to Work grant activities in LaCrosse and Wood counties are informing the MCH Program of successful policy, systems, organizational and environmental changes to build healthy nutrition and physical activity environments for children, youth, adults and communities. Integration opportunities are being explored with the Early Childhood Systems initiative and the WI Healthiest Women Initiative (WHWI). //2013//**

Federal Health Care Reform The Patient Protection and Affordable Care Act (ACA) includes a

number of MCH-related provisions. The expansion of insurance coverage to many women and children will mean that women will have coverage for preconception and interconception care and CYSHCN will have better insurance coverage. Provisions to increase access to community health centers, school-based clinics and health care homes in Medicaid offer additional opportunities for collaboration. Workforce provisions to increase the primary care and public health workforce, promote community health workers, and support training in cultural competency and working with individuals with disabilities are of special interest to Title V.

The MCH population will greatly benefit from funds to expand prevention and public health programs. Three new sections in Title V create significant opportunities to enhance MCH activities in WI.

- Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Programs support goals of DHS in healthy birth outcomes, maternal health, infant and child health and development, injury prevention, domestic violence prevention and substance abuse and mental health prevention and treatment. The grant builds upon and expands the reach of the MCH program's work over the last decade to implement ECCS and LAUNCH grants which support effective, integrated systems of services for young children up to age 8 across agencies in key areas of health and development including social-emotional wellness, safety, early education, and parent support and skill building.
- Personal Responsibility Education (PREP) grants to states will fund programs to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections including HIV/AIDS. Education also includes adulthood preparation subjects. These funds could be used to expand the work of the Milwaukee Adolescent Pregnancy Prevention Partnership (MAPPP) serving African American teens ages 15-19 to provide outreach and access to the Family Planning Waiver. Activities may include expansion of Plain Talk by the City of Milwaukee Health Dept focusing on parent-child communication related to sexual health, and expansion of life skills development training currently provided by New Concepts.
- Services to Individuals with a Postpartum Condition and their Families grants will fund health and support services for women with or at risk for postpartum depression and postpartum psychosis. The MCH Program is positioned to apply for funds to: 1) Expand Women's Health Now and Beyond Pregnancy interconception services to include a focus on depression screening, referral and follow-up, 2) Implement a quality improvement project focused on postpartum depression with Prenatal Care Coordination Providers participating in regional provider meetings, 3) Integrate services to individuals with a postpartum condition into home visiting programs, and 4) Increase training to public health nurses and others via the new mental health certificate program, the endorsement program, and Pyramid training for social and emotional health.

***//2013/ The ACA MIECHV Program is being implemented in collaboration with Department of Children and Families (DCF). The State MCH Program works closely with ECCS, ECAC, and Project LAUNCH to insure cross program collaboration. PREP is funding 6 sites (4 in Milwaukee, 1 in Racine, and 1 in Beloit) that are using Making Proud Choices and Street Smart curricula and 3 adult preparation subjects. //2013//***

## LEGISLATIVE INITIATIVES

A number of initiatives from the 2009-2011 Legislative Session will directly benefit the MCH population of WI:

- Cochlear Implant Insurance Mandate--Insurance companies are required to provide coverage for hearing aids and cochlear implants for children
- Newborn Hearing Screenings--All infants born in WI are required to have a hearing screening with referrals to intervention programs for hearing loss
- Autism--Disability insurance policies and self-insured health plans sponsored by the state, county, city, town, village or school district are required to cover certain services for children with an autism spectrum disorder at a minimum of \$50,000/yr for intensive level services and \$25,000/yr for non-intensive services; A licensure and regulation program was created for autism

treatment behavior analysts

- Dental education outreach facility--\$10 million in state bonding will be provided to Marshfield Clinic to construct a facility to educate dental health professionals
- WI State Statute 253.16--Right to Breastfeed in Public was signed into law March 2010
- Clean Indoor Air Act--A comprehensive smoke-free workplace law covering all restaurants and taverns in WI will go into effect 07/06/2010
- Operating While Intoxicated--WI citizens who choose to drink and drive will face tough new penalties
- Farm to School--A statewide Farm to School Advisory Council, a statewide coordinator and grant program will support Farm to School programs, with schools accessing fresh fruits and vegetables from WI farms
- Healthy Youth Act--Schools that teach sex education are required to provide comprehensive information about abstinence and sexually transmitted infections and pregnancy prevention strategies such as birth control and condom use
- Expedited Partner Therapy--Health care professionals are allowed to prescribe medication to treat certain sexually transmitted infections for the sexual partner of a patient without requiring an exam
- HIV--Updates to WI statutes improve HIV testing, disclosure and reporting; Testing for pregnant women will be done unless the woman opts out; a medical home pilot will be established for patients with HIV and Medicaid
- Mental Health Parity--Group Health insurance policies are required to cover addictions and mental disorders on par with other illnesses; Unlike the federal parity law, the WI bill applies to insurance policies provided by small employers as well as big companies; The measure also eliminates the minimum annual coverage requirements that insurers previously had to provide
- BadgerCare Plus Basic--See below

***//2013/ Attachment III.A.-Legislation Grid, developed by the MCH Advisory Group Policy and Action subcommittee, identifies policy changes that passed in the legislature, categorized by: 1) direct impact on MCH populations, 2) relevant to health, not necessarily MCH, 3) impact on social determinants and 4) other. //2013//***

## BADGERCARE PLUS

DHS recently implemented a number of important health care reform initiatives designed to increase access to health care for more low income WI residents. One of the most significant changes in improving access to health care in WI has been the implementation of the BadgerCare Plus program (<http://dhs.wisconsin.gov/badgercareplus>) to include a wider group of eligible participants.

BadgerCare Plus is WI's Program for Title XIX (Medicaid) and Title XXI (SCHIP) for children, providing health insurance coverage for all children up to age 19, regardless of income; for pregnant women with incomes up to 300% of the federal poverty level; for parents, caretaker relatives, and other adults with qualifying incomes. See (<http://dhs.wisconsin.gov/badgercareplus>) for a complete description of those eligible.

According to the two-year average comparison based on national census data from 2006-2007, WI had the second lowest uninsured rate for children at 5.3% and the third lowest uninsured rate for the non-elderly population (0-64 years) at 9.6%. However, census data from 2008 released 9-09 indicates that WI slipped to fourth place for the overall rate of uninsured, behind Massachusetts, Hawaii, and Minnesota.

According to the 2007 WI Family Health Survey:

- 91% of WI residents were covered by health insurance for the entire year
- 5% had no coverage for the entire prior year and of those, 90% were childless adults
- Significant decrease in the rate of uninsured from 8% in 2006 to 6% in 2007
- Percentage of children 0-17 uninsured all year decreased from 4% in 2006 to 2% in 2007

- Over 99% of the elderly have coverage
- African American, Hispanic and American Indian adults, ages 18-64, were more likely to be uninsured than were non-Hispanic white adults of the same age group
- 9% of children 0-17 living in poor or near-poor households were uninsured for part or all of the past year, compared to 3% of children in non-poor households

In February 2008, the BadgerCare Plus program expanded coverage to all uninsured children and increased the program income limits for pregnant women, parents, and self-employed residents. Since then there has been an enrollment increase in WI's Medicaid program and Children's Health Insurance Program (CHIP) of 137,522 individuals.

More recently, the BadgerCare Plus Core Plan was implemented for low-income, childless adults without health insurance. As of 10/09/2009, over 32,000 childless adults have been enrolled in the Core Plan. Because the number of applications submitted exceeds the available funding, DHS suspended enrollment on October 9 and established a waitlist. In the 2010 Legislature, a proposal to implement a self-funded Basic Plan for those on the sizable Core Plan waiting list was enacted into law. The Legislature approved the basic plan which BadgerCare Plus officials hope will serve as a bridge to the more comprehensive coverage options offered by the enactment of national health systems reform.

In addition, DHS is in the process of expanding the Family Care entitlement program statewide and recently implemented the Long Term Care Partnership Program to allow moderate income consumers access to affordable long-term care insurance regardless of assets. DHS is planning to eliminate the "asset limit" for blind and disabled children who are in need of Medicaid long-term care.

State legislation was recently enacted to increase the maximum age for dependent coverage. Beginning January 1, 2010, adult children will be able to stay on their parents' health insurance plan until they reach age 27, regardless of their school status.

While the expansion of BadgerCare Plus is a significant improvement for low income residents of WI, it does not address the underinsured or the adult population with income above program limits. It also does not address the rising cost of insurance premiums or the decreasing rate of employer sponsored insurance.

ACCESS is a set of online tools developed by DHS (<https://access.wisconsin.gov/access>), for public assistance programs, including FoodShare, Healthcare, Family Planning Waiver, and Child Care, that allows customers and prospective customers to assess eligibility for programs, check case benefits and report case changes and online program application. For many, this is an appealing alternative to office visits and phone calls. Although they may not own a personal computer, a growing number of customers do have access to computers -- through friends or family, at work, at school or at the library. Others use online tools with the help of staff/volunteers at food pantries, clinics, HeadStart programs, Community Action Agencies, WIC clinics, Job Centers, etc.

The goals of the ACCESS project are to:

- Increase participation in FoodShare, Medicaid, and other programs
- Improve customer service and satisfaction
- Improve FoodShare payment accuracy
- Ease workload for local agencies

Some of the key features of ACCESS are:

- Design was based on direct input from customers. More than 15 focus groups and design review sessions were undertaken with low-income residents of WI
- Friendly, encouraging text written at a 4th grade reading level
- Personalized pages, results and next steps

- Quick, simple, intuitive navigation
- Assurance about privacy. Some are nervous about giving personal information online

The major components of ACCESS are:

- Am I Eligible? -- A 15-minute self-assessment tool for:
  - \* FoodShare
  - \* All subprograms of Medicaid
  - \* SeniorCare and Medicare Part D
  - \* Women, Infants and Children (WIC)
  - \* The Emergency Food Assistance Program
  - \* School meals and summer food assistance
  - \* Tax credits (EITC, Homestead and Child Credit)
  - \* Home Energy Assistance
- Check My Benefits -- An up-to-date information segment (begun 09/30/2005) that includes:
  - \* Medicaid, FoodShare, SeniorCare, Child Care, SSI Caretaker Supplement benefits
  - \* Information based on why customers call their workers
  - \* Provides data directly from CARES (automated eligibility system)
  - \* Data is "translated" to make it more understandable
  - \* Data is furnished real time at account set-up, and is then updated nightly
- Apply For Benefits -- An online application for FoodShare, Medicaid, the Family Planning Waiver program, and Child Care

//2012/ The Governor's budget calls for a \$500 million cut from WI's Medicaid Programs over two years which may include changes in eligibility and services. Elimination of family planning only services for men is also proposed. Recent legislation gives the DHS Secretary the ability to make changes to the program. In March 2011, 460,887 children and 18,887 pregnant women were enrolled in BadgerCare Plus, an increase of 150,850 children and 3,251 pregnant women since mid-January 2008. As of March 19, 2011, DHS is no longer signing up new members in the BadgerCare Plus Basic Plan although it will continue to serve those already enrolled. The Basic monthly premium is also increasing to \$200 starting with the payment due May 5 for June 2011 coverage. //2012//

***//2013/ Certain Medicaid changes in eligibility and services were approved 4/27/12 by CMSO. These changes will affect income-eligible non-pregnant, non-disabled adults above 133% of the Federal Poverty Level (\$25,390 for a household size of three) and do not apply to children. Beginning July 1, 2012, there will be changes to:***

- ***Monthly premiums (depending on income)--Some members will be required to pay premiums and those who already do may see increases to their existing premiums. Individuals who do not pay their premium will not be eligible for 12 months.***
- ***Rules regarding access to employer-sponsored health insurance--Individuals described who have access to affordable health insurance through their employer will be asked to utilize that coverage rather than the publicly funded option.***
- ***Retroactive eligibility--Members described above will no longer be eligible for three months of backdated eligibility.***

***Family planning-only services for men continue at this time. In March 2012, 422,887 children and 18,447 pregnant women were enrolled in BadgerCare Plus. See also HSCI #6A and #6B for proposed eligibility changes and ([http://legis.wisconsin.gov/lfb/publications/Miscellaneous/Documents/2012\\_01\\_26\\_WILeg\\_MA.pdf](http://legis.wisconsin.gov/lfb/publications/Miscellaneous/Documents/2012_01_26_WILeg_MA.pdf)) for a memorandum that summarizes the current status of WI's Medical Assistance Program. //2013//***

DATA SYSTEMS

The State Systems Development Initiative (SSDI) Program carries out activities identified as essential in improving data capacity for the Title V MCH Program: 1) providing leadership to the needs assessment process, 2) assuring availability and utilization of data to drive MCH work at the local, regional and state levels and across stakeholders, 3) linkage activities such as the Newborn Health Profile, and 4) increasing access to and strengthening use of MCH related data within the framework of the strategic planning process. The MCH program staff administers and supports several data systems including SPHERE, PRAMS, WE-TRAC, and WBDP.

SPHERE: a web-based Secure Public Health Electronic Record Environment for collecting data for MCH, CYSHCN, and Family Planning/Reproductive Health; developed in 2002 and released 8/2003. SPHERE is a comprehensive system to document and evaluate public health activities and interventions at the individual, household, community, and system level. It utilizes 18 interventions as the framework for the system based on the "Intervention Model" (Minnesota Wheel) to document services provided. These interventions include: Surveillance; Disease and Health Event Investigation; Outreach; Case-Finding; Screening; Referral and Follow-up; Case Management; Delegated Functions; Health Teaching; Counseling; Consultation; Collaboration; Coalition Building; Community Organizing; Advocacy; Social Marketing; Policy Development; and Policy Enforcement. Subinterventions are associated with each Intervention and some include detail screens. There are currently 1,484 SPHERE users (active and inactive) representing 159 local organizations including all LHDs, Regional CYSHCN Centers, private not-for-profit agencies, private agencies including hospitals and clinics, and tribal health centers. Currently there are 238,143 clients in SPHERE and 963,464 activities. In 2009, SPHERE was used to document public health activities on 52,081 unduplicated clients with 153,488 Individual Public Health Activities; 2,790 Community Activities, and 1,494 System Activities.

Public health services provided to individual clients are reported as a snapshot in time. The Infant Assessment Summary Report based on infant assessments entered into SPHERE tells how many infants are being breastfed, sleeping in the back position, up-to-date on immunizations and well-child exams, and use a car seat. These data allow an agency to evaluate services that are being provided and the outcomes of those services. SPHERE required data is used for reporting the number of unduplicated clients served by the Block Grant and some outcome data.

DPH collaborates with the Office of Policy and Practice, Vital Records to use SPHERE to transmit confidential birth record reports to LHDs. Leveraging the existing security infrastructure of SPHERE ensured that access to birth records was restricted to only those individuals with assigned permissions and only those records for their particular jurisdiction. Recent enhancements to SPHERE include populating birth record data to the Postpartum and Infant Assessment screens. In 2005, a governance structure for the DPH Public Health Information Network (PHIN) was established. PHIN consolidates multiple systems into one initiative using a common set of functions. PHIN is the platform for integrated public health data in WI. SPHERE is a Program Area Module within the PHIN.

SPHERE enhancements planned are: transfer of data from WIC into SPHERE, testing linkage of SPHERE birth record files and newborn hearing screening, additional reports and screens to support Title V Block Grant activities and address the recent findings of the MCH Needs Assessment, documentation and evaluation in SPHERE for services related to the Milwaukee Home Visitation Program, other Home Visiting Programs, and Medicaid billing.

SPHERE user groups exist in all 5 DPH regions, the MCH Central Office and CYSHCN Regional Centers. The statewide SPHERE Lead Team meets quarterly. A monthly WisLine web training is held featuring recent changes and enhancements to SPHERE.

MCH data sheets comparing annual state, regional, and local data are developed and updated yearly highlighting MCH priority areas, e.g. PNCC, Reproductive Health, Child Passenger Safety Seats, Infant Assessments, and Developmental Assessments. Home Visitation Projects are

piloting handheld devices using the ASQ, ASQ:SE, HOME Inventory, and Home Safety Assessment tools. Data on these tools is entered in the home on the handheld device and uploaded to SPHERE.

**PRAMS--Pregnancy Risk Assessment Monitoring System:** In April, 2006, WI was awarded a five year PRAMS grant by CDC. African American women are oversampled because their infant mortality rates have been identified as being higher than white infant rates. WI PRAMS surveys a random sample of moms who have had a live birth, stratified by White, non-Hispanic; Black, Hispanic/Latina; and, Other, non-Hispanic. Activities over the five years of the grant include: establishing data-sharing agreements with Medicaid and WIC to obtain telephone numbers; steering committee meetings; establishing survey mailing procedures; submission of revised protocols to CDC for approval; multiple presentations and outreach activities to WI PRAMS partners including WIC and prenatal care providers; analysis of data; and presentations such as "What Moms Tell Us" provided at the statewide Healthy Babies Summit and Association of Women's Health, Obstetric, and Neonatal Nurses Conference, October 2009. PRAMS results provide stark evidence of major disparities in household income, postpartum depression, co-sleeping practices, and pregnancy intention. The weighted response rate was 68.7% in 2007 and 66.1% in 2008. (See Attachment III.A. Table 1)

**WI Birth Defects Registry (WBDR):** The WBDR is a secure, web-based system that allows reporters to report one birth defect case at a time or upload multiple reports from an electronic medical records system. Reporters may also submit a paper form to the WBDR state administrator for inclusion in the registry. The WBDR collects information on the child and parents, the birth, referral to services, and diagnostic information for one or more of 87 reportable conditions. From mid-2004 through December 31, 2009, the WBDR received 2,652 birth defect reports from 68 organizations. In 2010, it is expected that 2 large health systems will begin submitting reports from their electronic medical records. The WBDR is piloting a transfer enhancement ascertainment pilot with Children's Hospital of WI and the Medical College of WI to transfer congenital heart defects. The WBDR will participate in an Environmental Public Health Tracking project funded by the CDC to the Bureau of Environmental and Occupational Health that will attempt to match birth defects to known environmental hazards (<http://dhs.wisconsin.gov/health/children/birthdefects/index.htm>).

**WE-TRAC--WI Early Hearing Detection and Intervention (EHDI) Tracking Referral and Coordination:** a web-based data collection and tracking system created through a partnership between WI Sound Beginnings and State Lab of Hygiene (SLH). The system is used regularly by 350 users, including birth unit staff, midwives, nurses and audiologists. WI Sound Beginnings, the state's EHDI program, also uses WE-TRAC to ensure that every newborn has a hearing screening by 1 month of age, and if needed, receives diagnostic services by 3 months of age, and is enrolled in early intervention by 6 months of age. Ninety-eight percent of birth hospitals in the state use WE-TRAC and have the ability to make electronic referrals, transfer cases from one organization to another, and systematically transfer responsibility for follow-up care. The system also tracks organization specific information and statewide aggregate information.

/2012/ The data systems discussed continue to provide important information about the MCH populations. Additionally, the first module of the WI Statewide Vital Records Information System (SVRIS) which includes births and fetal deaths is now live as of 01/03/2011. Training has occurred throughout the spring and it is anticipated that the statewide electronic system will be fully adopted by 04/05/2011. The SVRIS will allow more timely data to be available to the MCH Program and partners from the previously utilized paper-intensive process. //2012//

***/2013/ 100% of birth hospitals now utilize the WE-TRAC system and the pool of users continues to expand. WE-TRAC also now collects information from SVRIS in order to assure every baby born in WI is screened for hearing loss.***

***Enhancements have been made to SPHERE to capture data and information on the Early***

***Childhood Systems work done by MCH funded projects. These enhancements include the MCH Core Competency Assessment Tool and the Partnership Tool for the WI Healthiest Families Initiative (WHFI). The MCH Core Competency Tool is completed as an agency assessment of 29 competencies in 12 domains and includes skill level, methods used to develop the competency, application to their work, and TA requests. The Partnership Tool collects information on all partner representations and contributions. SPHERE is used to collect data on indicators for the MIECHV benchmarks. Several enhancements are being made to SPHERE to measure these benchmarks.***

***Data collection and its analysis are important for WI's Title V Program to continue its collaboration with many DHS initiatives including, but not limited to: HW2020, the state health plan, the Minority Health Program (and its upcoming report), and WI Healthiest Women Initiative.***

***The public access on-line system WI Interactive Statistics on Health (WISH): available at: ([www.dhs.wisconsin.gov/wish](http://www.dhs.wisconsin.gov/wish)) has data modules for birth counts, teen births, injury mortality and hospitalization, BRFSS, population, and cancer; most of the modules may be analyzed by many variables, including, geography, age, sex and race/ethnicity.***

***PRAMS began its second 5-year funding cycle from the CDC on 5/1/12 (the project period ends 4/30/16). PRAMS data informed the WHFI. PRAMS fact sheets on depression and safe sleep were developed. //2013//***

## PRINCIPAL CHARACTERISTICS OF WISCONSIN

For the 2011 Title V Block Grant Application, the information is adapted from the following data sources: 1) U.S. Census Bureau, American Fact Finder, 2006-2008 American Community Survey (<http://factfinder.census.gov>), 2) U.S. Census Bureau, 2008 American Community Survey ([www.census.gov/acs](http://www.census.gov/acs)), 3) WI Dept of Administration, Demographic Service Center's 2009 Final Estimates Summary, 4) State of WI, 2007-2008 Blue Book, compiled by the WI Legislative Reference Bureau, 2007, 5) Anne E. Casey Foundation Kids Count Online Data ([www.aecf.org/kidscount/data.htm](http://www.aecf.org/kidscount/data.htm)), 6) WI Dept of Health Services (DHS), Division of Public Health (DPH), Office of Health Informatics (OHI), WI Infant Births and Deaths, 2008 (P-45364-08). Nov. 2009, 7) WI DHS, DPH, OHI, WI Deaths, 2008 (P-45368-08). Oct. 2009, 8) WI DHS, DPH, OHI, WI Health Insurance Coverage, 2008 (P-45369-08). Dec. 2009, 9) WI DHS, DPH, OHI, WI Interactive Statistics on Health (WISH) data query system, ([www.dhs.wisconsin.gov/wish/](http://www.dhs.wisconsin.gov/wish/)), 10) WI Council on Children and Families ([www.wccf.org](http://www.wccf.org)), 11) Center on WI Strategy (COWS), ([www.cows.org](http://www.cows.org)), and 12) U.S. Bureau of Labor Statistics, Regional and State Employment and Unemployment Summary ([www.bls.gov/news.release](http://www.bls.gov/news.release)).

/2012/ No significant change. //2012//

***//2013/ No significant change. //2013//***

### Population and Distribution

WI's population estimate on November 1, 2009, was 5,688,040, a change of 6% from the 2000 census, according to the WI Dept of Administration.

Although WI is perceived as a predominantly rural state, it is becoming increasingly urbanized as reflected by changes from the 2000 census to 2009 population estimates. Of WI's 72 counties, there were 9 with a population over 150,000; Milwaukee County was the only one of these counties to have a negative percent population change from 2000 to 2009. Eleven counties grew significantly since the 2000 census; Dane County (where Madison, the state capitol, is located) was the 2nd largest county and also experienced 11.0% growth since 2000. There are 13 municipalities with populations over 50,000, ranging from the City of Milwaukee (population

584,000) to Sheboygan (50,400). The majority of these cities are clustered primarily in the south central (Madison, Janesville, Beloit), southeast (Waukesha, Milwaukee, Kenosha, Racine) and along Lake Michigan, the Fox River Valley (Appleton, Oshkosh, Green Bay, Sheboygan). The others are in central (Eau Claire) and west central (LaCrosse) WI. According to the 2008 Family Health Survey estimates, 11% of the state's household population lives in the City of Milwaukee, 60% lives in the balance of Milwaukee County and the other 24 metropolitan counties, and 28% lives in the 47 non-metropolitan counties. Despite this strong growth in major metropolitan areas, the City of Milwaukee has experienced a loss of almost 13,000 residents during the 2000s; Milwaukee County decreased by more than 8,000 persons.

/2012/ In 2009, WI's official population was 5,679,639. //2012//

**/2013/ In 2010 according to the US 2010 Census, WI's official population was 5,686,986, an increase of 6% from 2000. //2013//**

#### Population Demographics

Sex and age: According to the 2006-2008 American Community Survey, females make up 50.3% of the state's population, the median age was 37.9 years, the estimate for number of children under age of 18 was 1,317,847 or about one-fourth of the state's population, and 13% were 65 years and older.

Race and ethnicity: The 2000 census was the first year that census respondents were allowed to identify themselves as being more than one race. About 1.2% of WI individuals selected multiple races. The most recent estimates (2006-2008) indicate that 1.4% of WI residents reported two or more races; although this change is not significant, it does represent the changing dynamics of WI's population. (See Attachment III.A. Table 2)

/2012/ No significant change. //2012//

**/2013/ Females made up 50.4% of the state's 5,686,986 population, the median age was 38.5 years, the number of children under the age of 18 was 1,339,492, or 23.6% of the state's population, and 13.7% were 65 years and older. //2013//**

#### Employment and Poverty

In 2004, WI's unadjusted unemployment rate was 4.9%, compared to the U.S. rate of 5.5%. Since then, according to the Bureau of Labor Statistics in 2009, WI's 2009 unemployment rate was 8.5%, compared to the U.S. rate of 9.3%. However, these rates do not reflect the U.S. economic crisis since the fall of 2007. In March 2009, WI's unemployment rate jumped to its highest rate in 26 years, 9.4%, passing the national rate of 9.0%. The decline of the auto industry has hit WI especially hard after General Motors closed plants in Beloit and Janesville. In March 2010, the Metropolitan Statistical Areas of Janesville, Racine, Sheboygan, and Wausau had unadjusted unemployment rates of 12.8%, 11.5%, 10.0%, and 10.6% respectively. In the City of Milwaukee, estimates show that almost 50% of African American men are unemployed. WI women comprise less than 50% of the state's workforce, but they make up 55% of the state's working poor, those in households with income below the federal poverty level. Although there are a few signs of economic recovery in WI, such as slight gains in the manufacturing sector, the employment picture is stagnant. As families struggle, minorities carry the burden of poverty as recent estimates from the 2008 American Community Survey show. (See Attachment III.A. Table 3)

/2012/ In March 2011, WI's unadjusted unemployment rate was 8.1%, compared to the U.S. rate of 9.1%. //2012//

**/2013/ In March 2012, WI's seasonally adjusted unemployment rate was 6.9%, compared to the U.S. rate of 8.2%. //2013//**

Furthermore, WI PRAMS data indicate significant disparities for household income. (See Attachment III.A. Table 4)

The range by county of the percentage of children who live in poverty is wide, from the counties with the highest poverty rates for children (Milwaukee at 25.2% and Vernon at 22.0%) to the counties with the lowest poverty rates for children (Ozaukee at 5.3% and Waukesha at 4.5%).

Compared to other states, using these indicators, WI's overall rank is 10. These indicators do not reflect the significant disparities by racial/ethnic group in the state; selected indicators are discussed below using the most recent data available. (See Attachment III.A. Table 5)

***/2013/ Compared to other states, using these indicators, WI's overall rank in 2011 was #12. //2013//***

Vital statistics: Births to single mothers have increased slightly from 25% in 1991, 27% in 1993 and 1995, and 28% in 1996 and 1997 to 31% in 2003, and 37% in 2008. The marriage rate in 2010 was 5.3/1,000 total population, lower than the 2007 rate of 5.6, and lower than the U.S. provisional marriage rate of 7.0 for the 12 months ending in June 2009. The divorce rate in 2008 was 2.9/1,000, lower than the rate of 3.0 in 2007. Fifty-three percent of WI divorces in 2008 involved families with children under 18 years of age. In 2008, there were 46,526 deaths in WI for a rate of 8.2/1,000 population, slightly lower than recent years; this rate is similar to the U.S. rate. In 2008, there were 9 maternal deaths.

/2012/ In 2009, 38% of births were to single mothers, compared to 30% in 1999. WI's marriage and divorce rates remained about the same with only slight changes that were not significant. In 2009, there were 45,598 deaths in WI for a rate of 8.0/1,000 the lowest rate ever in WI. In 2009, there were 13 maternal deaths; 4 more than in 2009. //2012//

***/2013/ In 2010, 37% of births were to single mothers, compared to 30% in 2000. WI's marriage rate in 2010 was the same as in 2009, 5.3/1,000 population, and the divorce rate was 3.0 compared to 2.9 in 2009. In 2010, there were 47,212 deaths for a rate of 8.3/1,000 population. There were 11 maternal deaths in 2010. //2013//***

- Infant mortality--Often used as a measure of a society's overall well-being, infant mortality is a significant issue in WI. The overall infant mortality in 2008 7.0/1,000 live births; the White rate was 5.9, a slight increase from 5.3 in 2007, and a marked decrease from 7.2 in 1990. The Black infant mortality rate in 1990 was 19.7; in 1997 it was at its lowest for the past two decades at 13.4. Since then it has increased steadily to 18.7 in 2001. Aside from some fluctuations the 2007 and 2008 rates are the lowest of this decade; nonetheless, in 2008, the ratio of the Black infant mortality rate to White was 2.3. The Hispanic/Latino infant mortality rate for 2008 was 7.0 deaths/1,000 births to Hispanic/Latina women, compared to 6.4 in 2007 and 11.0 in 1998. The number of American Indian and Laotian or Hmong and Other Asian infant deaths are too few in a single year to calculate annual rates. The three-year average Laotian/Hmong rate for 2006-2008 was 7.2, compared to 7.6 in 2001-2003. For American Indians it was 10.1 in 2006-2008, compared to 12.9 in 2001-2003.

/2012/ WI's overall infant mortality in 2009 was 6.0 deaths/1,000 live births, compared to 7.0 in 2008 and 6.7 in 1999. The White rate was 4.9 deaths/1,000; a decrease from 5.9 in 2008 and 5.7 in 1999. The Black/African American rate was 14.3 deaths/1,000, compared to 13.8 in 2008, and 14.9 in 1999. The Hispanic/Latino infant mortality rate in 2009 was 5.5 deaths/1,000, compared to 7.0 in 2008, and 7.7 in 1999. The number of American Indian and Laotian or Hmong and Other Asian infant deaths are too few in a single year to calculate annual rates. The three-year average Laotian/Hmong rate for 2007-2009 was 7.9, compared to 7.6 in 2001-2003. The Other Asian infant mortality rate in 2007-2009 was 6.0 compared to 5.7 in 2005-2007. //2012//

***/2013/ WI's overall infant mortality in 2010 was 5.7 deaths/1,000 live births, compared to 6.0 in 2009 and 6.6 in 2000. The White rate was 4.9 (the same as in 2009). The Black/African American rate was 13.9 deaths, lower than 14.3 in 2009 and 16.8 in 2000. The Hispanic/Latino infant mortality rate in 2010 was 4.4, compared to 5.5 in 2009 and 4.7 in 2000. The number of American Indian and Laotian or Hmong and Other Asian infant deaths were too few in a single year to calculate annual rates. Three-year averages for 2008-2010 are: American Indian: 7.3 compared to 15.8 in 1988-1990; Laotian or Hmong: 7.8 compared to 9.0 in 1994-1996; and Other Asian 5.6 compared to 5.3 in 2001-2003. //2013//***

• Low birthweight/preterm--In 2008, 7.0% (5,051) of all births were infants with low birth weight; the rate for Black infants was 13.0%, White infants 6.3%, American Indian, Hispanic/Latinos, Laotian/Hmong, and other Asians were 8.0%, 6.3%, 7.9%, 7.0% and 6.9% respectively. In 2008, 11.1% (7,970) of infants in WI were born prematurely with a gestation of < 37 weeks. Non-Hispanic Black women had the highest percentage of premature babies 16.8%, followed by teenagers less than 18 years old 16.0%, women who were unmarried 13.5%, women who smoked during pregnancy 13.3%, and American Indian women 12.7%.

/2012/ In 2009, 7.1% of all births, slightly higher than in 2008, were infants with low birthweight; the rate for Black infants was 14.2%, White infants 6.3%, American Indian, Hispanic/ Latinos, Laotian/ Hmong and other Asians were 5.0%, 6.1%, 6.8%, and 7.9% respectively. In 2009, 10.8% (7,663) of infants in WI were born prematurely with a gestation of < 37 weeks. Non- Hispanic Black women had the highest percentage of premature babies 17.2%, followed by teenagers less than 18 years old 16.5%, women who were unmarried 12.9%, women with < a high school education 12.8%, and women who smoked during pregnancy 12.7%. //2012//

***/2013/ In 2010, 7.0% of all births (slightly lower than in 2009, and the same as in 2008) were infants with low birth weight; the rate for Black infants was 13.8%, White infants 6.2%, American Indian 7.5%, Hispanic/Latinos 5.8%, Laotian/Hmong 7.4% and Other Asian 8.3%. In 2010, 10.8% of infants were born prematurely with a gestation of <37 weeks; non-Hispanic Black women had the highest percentage 17.5%, followed by teenagers less than 18 years old 14.8%, women who were unmarried 13.0%, women with < a high school education 12.8%, and women who smoked during pregnancy 12.2%. //2013//***

• First trimester prenatal care--In 2008, 82.2% of pregnant women received first trimester prenatal care. The race/ethnic group with the highest rate was White women at 86.2%, followed by other Asian 82.2%, American Indian 72.5%, Hispanic/Latina 71.3%, African American 70.2%, and Laotian/Hmong 56.1%.

• Teen birth rate--In 2008, for teens <20 years, there were 6,096 births (31.3/1,000), or 8.5% of all births in WI. Teen birth rates for <20 years by race/ethnicity in WI, 1998 to 2008. (See Attachment III.A. Table 6)

/2012/ In 2009, 83.4% of pregnant women received first trimester prenatal care. The race ethnic group with the highest rate was White women 86.8%, Other Asian 82.9%, American Indian 76.6%, Hispanic/Latina 74.1%, Black/African American 73.2%, and Laotian/Hmong 62.3%.

In 2009, for teens <20 years, there were 5,855 births (29.3/1,000) or 8% of all births in WI. 90% of births to teens were to single mothers. By race/ethnicity, the highest proportion of teen births were to African Americans at 21%, followed by American Indians at 17%, Hispanic/Latina at 15%, and Laotian/Hmong at 14%. White and Other Asian teens had the lowest proportion of teen births at 5% and 3% respectively. //2012//

***/2013/ In 2010, 84.2% of pregnant women received first trimester prenatal care. The race ethnic group with the highest rate was White 87.7%, Other Asian 81.2%, Hispanic/Latina 74.5%, Black/African American 74.1%, American Indian 72.3%, and Laotian/Hmong 65.7%. In 2010, for teens <20 years, there were 5,147 births (26.2/1,000) or 7.5% of all births in WI. By race/ethnicity, the highest proportion of births were to African Americans 19.9%,***

***followed by American Indian 16.5%, Hispanic/Latina 13.1%, and Laotian/Hmong at 12.3%. White and Other Asian teens had the lowest proportion of teen births at 5.0% and 3.0% respectively. //2013//***

• Leading causes of death--In 2008, 54% of the leading causes of death were diseases of the heart, malignant neoplasms (cancer), and cerebrovascular diseases (stroke). For males, in 2008, accidents were the leading underlying cause of death for ages 1-44; cancer was the leading cause of death for ages 45-84. For females, accidents were the leading underlying cause of death for ages 1-25; cancer was the leading cause of death among women ages 25-84. (See Attachment III.A. Table 7)

/2012/ In 2009, there were 45,598 deaths of WI residents for a rate of 8.0/1,000 population, the lowest rate ever reported for WI and 928 deaths fewer than in 2008. The top five underlying causes of death by race did not change significantly for 2009. See the 'Healthy People at Every Stage of Life Framework' in Section III.A -- Overview. //2012//

***/2013/ In 2010, there were 47,212 deaths of WI residents for a rate of 8.3/1,000 population, slightly higher than the rate of 8.0 in 2009. Three underlying causes of death (cancer, diseases of the heart and cerebrovascular disease) accounted for 53% of the total deaths. For males, in 2010, the leading underlying cause of death for ages 1-44 was accidents; for men ages 45-84 it was cancer. For females, the leading underlying cause of death was accidents for ages 15-44; for girls ages 1-14 and women 45-84 it was cancer. By race/ethnicity, cancer and diseases of the heart were the two leading underlying causes of death in each race and ethnic group. //2013//  
An attachment is included in this section. IIIA - Overview***

## **B. Agency Capacity**

### **WISCONSIN STATE STATUTES RELEVANT TO TITLE V MCH/CYSHCN PROGRAM AUTHORITY**

The WI Legislature has given broad statutory and administrative rule authority to its state and local government to promote and protect the health of WI citizens. In 1993 WI Act 27, created Chapters 250-255 that significantly revised public health law for WI and created an integrated network for LHDs and the state health division. In 1998, Public Health Rules HFS 139 and HFS 140 were completed. HFS 139 outlines the qualifications of public health professionals employed by LHDs and HFS 140 details the required services necessary for a LHD to reach a level I, II, or III designation. In 2008 the 10 essential services of public health were added to Chapter 250 as a requirement of state and local health departments (s.250.03(1) (L). These important public health statutes provide the foundation and capacity to promote and protect the health of all mothers and children including CYSHCN needs in WI.

Chapter 250 defines the role of the state health officer, chief medical officers, the public health system, the power and duties of the department, qualifications of public health nursing, public health planning, and grants for dental services.

Chapter 251 describes the establishment of local boards of health, its members, powers and duties, levels of services provided by LHDs, qualifications and duties of the local health officer, and how city and county health departments are financed.

Chapter 252 outlines the duties of local health officers regarding communicable disease to include the immunization program, TB, STI, AIDS, HIV, and case reporting.

Chapter 253 ([www.legis.state.wi.us/statutes/Stat0253.pdf](http://www.legis.state.wi.us/statutes/Stat0253.pdf)) mandates a state MCH program in the DPH to promote the reproductive health of individuals and the growth, development, health and safety of infants, children and adolescents. This chapter addresses: state supplemental food

program for women, infants, and children, family planning, pregnancy counseling services, outreach to low-income pregnant women, abortion refused/no liability/no discrimination, voluntary and informed consent for abortions, infant blindness, newly added in 2010 newborn hearing screening, birth defect prevention and surveillance system, tests for congenital disorders, and Sudden Infant Death Syndrome.

Chapter 254 focuses on environmental health and includes health risk assessments for lead poisoning and lead exposure prevention, screening requirements and recommendations, care for children with lead poisoning/exposure, lead inspections, lead hazard reduction, asbestos testing, abatement, and management, indoor air quality, radiation, and other human health hazards.

Chapter 255 addresses chronic disease and injuries and outlines cancer reporting requirements, cancer control and prevention grants, breast and cervical cancer screening programs, health screening for low-income women, tanning facilities, and the Thomas T. Melvin youth tobacco prevention and education program.

## OVERVIEW OF AGENCY CAPACITY

The DPH, Bureau of Community Health Promotion, Family Health Section (FHS) is designated as WI's Title V MCH/CYSHCN Program. DPH collaborates with numerous state agencies and private organizations, LHDs and community providers. Supported by WI's strong partnerships and sound public health law, the FHS is well-positioned to provide prevention and primary care services for pregnant women, infants, children, including CYSHCN and their families that are family-centered, community-based, and culturally appropriate.

The amount of state General Purpose Revenue available to support the public health programs in WI is among the lowest in the nation. Thus, federal grants are the primary source of funding for the majority of public health infrastructure, services and activities. In addition to the Title V Block Grant, the FHS manages more than 20 grants that address a range of MCH services such as: screening and early intervention, injury prevention and surveillance, LAUNCH, ECCS, SSDI, and autism.

Approximately 60% of WI's Title V funds are released as local aids either as a non-competitive performance-based contract to tribes and LHDs who have "first right of refusal" or as a competitive request for proposal (RFP) for specific statewide or regional initiatives. The remaining approximate 40% supports the state infrastructure for the MCH Program. More detail can be found in Section D, Other MCH Capacity.

Based on 2005 needs assessment results, objectives for LHDs were developed to reflect MCH priorities and promote measurable outcomes funded through performance based contracts. In 2010, the most frequently implemented template objectives focus on: injury prevention (child passenger safety, safe infant sleep, home safety assessment) perinatal health (breastfeeding, postpartum home visit, evaluation of care coordination services) developmental screening (ASQ, ASQ:SE) and oral health (early childhood caries prevention).

Five statewide projects began in 7/1/05 through 12/31/10 for services to: improve infant health and reduce disparities in infant mortality; support a genetics system of care; improve child health and prevent childhood injury and death; improve maternal health and maternal care; and create a Parent to Parent (P2P) matching program for families with CYSHCN. A new cycle for the Regional CYSHCN Centers began 1/1/06 through 12/31/10 aligned with the six federal core outcomes as part of the President's New Freedom Initiative. In addition, Regional CYSHCN Centers partnered in the implementation of WI's MCHB funded CYSHCN Integration grant. HRSA selected WI as 1 of 7 Leadership States to promote the implementation of the six core components of a community-based system of services through the Medical Home concept.

/2012/ Based on the 2010 MCH Needs Assessment and priorities, MCH funds LHDs and tribal

programs to focus on systems building activities. In 2011, 51 LHDs are working toward developing a collaborative plan in partnership with key stakeholders for a community system that supports early childhood health and development. This Early Childhood Systems work includes 2 initiatives. Keeping Kids Alive (KKA) focuses on fetal, infant and child mortality review and prevention. WI Healthiest Families Initiative (WHFI) focuses on systems of services for family supports, child development, mental health and safety and injury prevention. Statewide projects provide support and technical assistance for KKA and WHFI. Other statewide projects include Genetics and the WI Healthiest Woman Initiative (WHWI).

A new 5 yr funding cycle began 1/1/11 for CYSHCN Regional Centers including Parent to Parent matching. CYSHCN hubs of expertise are funded in 2011 to support Medical Home, Family Health Leadership, Access/Health Benefits Counseling and Youth Health Transition. //2012//

***//2013/ In 2012, all LHDs are implementing WHFI and/or KKA activities with MCH funds.//2013//***

**SERVICES FOR PREGNANT WOMEN, MOTHERS, INFANTS** Reproductive Health  
A key goal of the WI MCH Family Planning, Reproductive/Sexual Health, and Early Intervention (FP/RSH/EI) Program is to provide quality, cost-effective, confidential contraceptive and related reproductive health care through a statewide system of community-based clinics. These clinics are medical homes for addressing a significant part of the primary and preventive care recommended for reproductive-age women: provided in specialized health care setting separate from but coordinated with their other sources of primary health care. Over 50,000 women receive care through this statewide system of services.

One of the highest priorities in this next 5-year cycle will be to increase access to services and quality of care. Guidelines (patient care and administration) will be updated, and quality assurance indicators/ performance measurements will be established to improve accountability for implementation and quality improvement. New standards of practice and priority areas will be introduced. These priority practices include improved access to: dual protection (simultaneous intervention for unintended pregnancy and STD risk reduction); emergency contraception; postpartum contraception; reproductive life plans; FPW eligibility screening and enrollment; medical homes for reproductive/sexual health and other primary health care; consistent health messaging; and screening, assessment and intervention for sexual violence and abuse, early intervention and continuity of care.

Improved partnerships with PNCC will be a high priority for implementing these new priority areas and establishing new standards of practice. The Women's Health Now and Beyond Pregnancy will be expanded to implement best practices developed in model projects with PNCC providers to improve timeliness of post partum contraception through new practice standards, reproductive life planning, healthy birth spacing, interconception, and women's health.

Screening and assessment for sexual assault and abuse is a new service priority because women who have experienced or witnesses violence (child physical or sexual abuse, sexual assault, and/or domestic violence) are at greater risk for complications around family planning and reproductive health. Women who have experienced violence are at risk for poor birth outcomes (low birth weight and pre-term), negative labor and delivery experiences, and difficulty in implementing and sustaining breastfeeding. Through MCH-funded programs serving women prenatally and postpartum 19% were identified as experiencing abuse and personal safety issues (SPHERE 2009). A new collaboration has begun between Family Planning/Reproductive Health, IVPP, WIC, and Maternal Health programs to explore message delivery, assessment and follow-up on issues related to violence for women utilizing these services.

The Title V MCH Program contracts with Health Care Education and Training, Inc. (HCET), which manages the Region V Title X Family Planning training project, to provide training and technical assistance on these and other 5-year priorities to community based health programs and private

health care providers.

/2012/ A competitive grant application was released and awards granted to community-based family planning programs for 2011-2015 grant cycle as part of the statewide system of services for which the MCH Program has responsibility. In the SFY 2011-12 and SFY 2012-13 proposed budget, state funding to support the statewide system of community-based family planning services (at s.253.07 (4)) will be changed. The effect on the continuation of local community-based services statewide is unknown, and continuation of local services in the short-term will depend on replacement of any reduced funding with local sources of revenue. MCH funds will continue to enhance local services to provide maternal, perinatal, and women's health care, to ensure timely continuity of care, to provide quality assurance based on established personnel and practice standards. //2012//

***/2013/ Statutory changes occurred in contract methodology and eligibility to receive State GPR funds and MCH funds. Organizations that provide abortion services, or that are affiliated with organizations that provide abortion services, are not eligible to receive these State GPR and MCH funds. The MCH Women's Health-Family Planning/Reproductive Health Program met these new contract requirements and continues to support a statewide system of community-based services. //2013//***

#### Preconception Health

The WI Association for Perinatal Care (WAPC) and the Infant Death Center of WI (IDCW) were funded to produce materials and provide education to support preconception services as part of the routine care for all women. In collaboration with Medicaid, DPH provided guidance on interconception services for women with a previous poor birth outcome identified through the Medicaid high-risk birth registry. The Women's Health Now and Beyond Pregnancy initiative extended interconception care for women receiving PNCC services.

In 2011, the Title V MCH Program will begin funding preconception initiatives that focus on: 1) integrating depression screening and tobacco cessation services into family planning/reproductive health programs, 2) integrating select preconception services into the routine care provided to women of childbearing age by the health plans of WI, and 3) establishing a WHWI and developing a preconception plan for the state. WI PRAMS 2007-08 data highlights the need for focused efforts related to preconception health: 45% of all and 67% of African American pregnancies are unplanned; 14% of all and 25% of African American women experience postpartum depression; 95% of the women who reported smoking in the past 2 years reported smoking in the 3 months prior to pregnancy; 53% of all and 62% of African American women did not take a multivitamin the month prior to pregnancy.

/2012/ The WHWI will include 3 forums in 2011 with public, private, and consumer partners to identify strategies and a plan to promote and integrate preconception health services. //2012//

***/2013/ See HSI 1A-2B //2013//***

#### Maternal Health

The WI Association for Perinatal Care (WAPC) is funded by the MCH Program through 2010 as the statewide project to Improve Maternal Care and Maternal Health. WAPC provides education and training to support perinatal practices in the hospital and clinical settings. Through multi-disciplinary committees in 2009-2010, WAPC developed an Algorithm for Preconception Care and the Methadone Project Educational Toolkit for clinical providers and the Expectant Father Wish List for community members. A conference is hosted annually and regional forums in 2009 provided education for health care providers on the use of antidepressants in pregnancy and while breastfeeding.

DHS established the WI Maternal Mortality Review Team (MMRT) in 1997 to collect, evaluate, and analyze all maternal deaths occurring in the state. This multi-disciplinary collaborative makes recommendation on maternal care practices to improve maternal outcomes. The MCH Program has partnered with WAPC to support this effort with case abstractions and reporting.

/2012/ The MCH Program is supporting MMRT with case abstractions and planning a report representing the last 5 years of findings. Collaborative efforts with the Injury and Violence Prevention Program and WIC look to standardize the methods and tools used to screen women for intimate partner violence across prenatal public health services. //2012//

***/2013/ A maternal mortality report and website are under development. Also see HSI 1A-2B //2013//***

## Infant Health

The Infant Death Center of WI (IDCW) is funded by the MCH Program through 2010 as the statewide project to Improve Infant Health and Reduce Disparities. IDCW brings partners together building coalitions to support the Healthy Birth Outcomes; Healthy Babies in WI and the Milwaukee Hospital Collaborative to support perinatal outcomes. In addition to individual bereavement support to families the IDCW provided education to public and private health care partners on safe infant sleep and reducing the risk of SIDS.

The Great Beginnings Start before Birth curriculum continues to be offered statewide to LHD and home visitation programs providing services to families during both the prenatal and postpartum period.

With an increase in sleep related infant deaths in the Southeast Region of WI, MCH has collaborated with the City of Milwaukee Health Department to hold a Safe Sleep Summit to focus on increasing awareness of preventable losses and develop a plan for improving messages on safe infant sleep to the community.

/2012/ CHAW houses the IDCW and is providing technical assistance and training to LHDs who are participating in the Keeping Kids Alive (KKA) initiative of the MCH Early Childhood Systems Initiative. CHAW staff will participate in the WHWI forums in 2011 and continues to serve on the MCH Advisory Committee. //2012//

***/2013/ See Needs Assessment and HSI #3A-4C for discussion of WHFI and KKA. //2013//***

## Newborn Screening

In WI, infants are screened for 47 different congenital disorders and for hearing loss. Infants diagnosed receive referral, follow-up care and links to services. The early screening team includes staff from the congenital disorders, early hearing detection and intervention (EHDI), and the statewide genetics program. The Newborn Screening (NBS) Staff collaborate with the State Lab of Hygiene to continuously improve WI's early screening initiatives and promote the health and well-being of newborns and their families. The NBS Advisory Committee and 6 subcommittees meet biannually to advise and provide expertise regarding NBS testing, diagnosis, and patient care. Staff members participate in the Region 4 Genetics Collaborative to share resources, best practice models and new technologies related to newborn screening.

/2012/ The NBS Task Force, an Ad-hoc committee, has been established to look at the sustainability of the program and the criteria for adding/deleting conditions. //2012//

***/2013/ A Hearing Screening Subcommittee was formed with the Chair reporting to the Umbrella Committee to further integrate newborn screening programming. Based on recommendations of the Metabolic Subcommittee/Umbrella Committee, WI now screens***

***for 45 conditions including hearing (3 metabolic conditions were deleted). Section 253.13 (2), Stats., require DHS to impose a fee of \$109 for newborn screening by rule, where in the past the WSLH was responsible to impose a fee by policy. //2013//***

#### SERVICES FOR CHILDREN AND ADOLESCENCE Child Health

Children's Health Alliance of WI (CHAW) receives MCH funding for statewide initiatives to address childhood injury and violence prevention (IVP). CHAW supports training, technical assistance and data analysis for LHDs and other community partners. An emphasis has been placed on initiating the Child Death Review (CDR) process in more counties. The maintenance of a statewide network with training and resources dedicated to childhood IVP has been expanded to include on-line trainings.

In 2011 the MCH Program will develop the Keeping Kids Alive project through a statewide partnership. The focus of the project will be to establish systematic reviews of fetal, infant, and child deaths throughout WI and to support the implementation of actions based on findings both locally and statewide. The project will provide technical support to local death review and community action teams; to promote the use of standardized data collection e.g. National CDR system and FIMR system.

In 2011, MCH dollars will also support local and statewide efforts to build an early childhood system of integrated and coordinated health promotion and prevention for children and their families incorporating 4 Bright Futures health promotion themes: family supports, child development, mental health, and safety/injury prevention.

/2012/ See update for Infant Health. //2012//

***/2013/ See Needs Assessment and HSI #3A-4C for discussion of WHFI and KKA. //2013//***

#### Systems of Care

State initiatives to promote connected service systems for children and adolescents have been implemented under the leadership of the MCH Program. Since 2003 MCH has partnered with many state public and private agencies to implement the Early Childhood Comprehensive System (ECCS) grant. ECCS has strengthened the linkages among key partners with a broad focus on early childhood policies, programs, and services. Work over the last year has strengthened links among providers of service to young children in the areas of the five critical components of the ECCS grant: access to health insurance and medical home, mental health and social-emotional development, early care and education, parent education and family support by linking with the state collaborative, WI Early Childhood Collaborating Partners (WECCP).

Because of the strong system work that occurred by linking ECCS with WECCP, new opportunities have arisen that will further strengthen the movement toward a connected system of programs at the state level to support services for young children at the state and community levels. WI was successful in competing for a Project LAUNCH grant awarded September 2009 because of the foundational work of ECCS and the MCH Program.

The application process for WI Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), a cooperative agreement funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), was built upon existing work and relationships that have been at the forefront of efforts of the ECCS grant. Project LAUNCH will focus work to promote child wellness in target neighborhoods of the City of Milwaukee that are excessively burdened by issues associated with poor child health including: a high percentage of infants born at low birth weight, late entry of pregnant women into prenatal care, childhood lead poisoning, high rates of sexually transmitted diseases, high rates of poverty and unemployment, lack of education, excessive use of drugs, high crime rates, and high teen pregnancy rates.

ECES grant activities complement the work of Project LAUNCH and both efforts will be coordinated to inform the work of Governor Jim Doyle's Advisory Council on Early Childhood Education and Care (ECAC). The ECAC was appointed in 2008 as part of the Head Start reauthorization that required council of key state department leaders and partners of influence to recommend policy that affects the system of services for young children and their families.

In 8/09, the MCH Program initiated work to promote integration of Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, Third Edition, into public health practice for children in WI. Released in 2008, Bright Futures provides detailed information on well-child care for health care practitioners. In partnership with American Academy of Pediatrics (AAP), an all day workshop was held on 08/17/09 to provide overview of the use of Bright Futures in public health practice. WI is providing a series of live webcasts jointly sponsored by the AAP and the DPH, FHS. During 2010, webcasts will focus on the needs of public health nurses and each will feature a specific Bright Futures theme: oral health, injury prevention, healthy nutrition, and healthy weight.

/2012/ In May 2011, MCH Program completed the Bright Futures integration training for local public health departments. Archives of sessions are at [www.dhs.wisconsin.gov/health/mch/BrightFutures/index.htm](http://www.dhs.wisconsin.gov/health/mch/BrightFutures/index.htm) //2012//

***/2013/ All Project LAUNCH strategies have been implemented collaboratively with the DHS MCH Program, DCF and the City of Milwaukee Health Department. ECES is directly influencing work of the ECAC including development of a comprehensive screening and assessment process, creation of a longitudinal data system, and implementation of the Infant and Early Childhood Mental Health Competency and Endorsement System. //2013//***

#### Adolescent Health

WI has been in a leadership role by having its Youth Policy Director, as the President of the National Network of State Adolescent Health Coordinators, participate in drafting priorities for the new Federal Office of Adolescent Health and help to develop a national adolescent health strategic plan.

/2012/ The Youth Policy Director is working with other state adolescent health coordinators to address resiliency approaches within the context of social determinants and health disparities.

WI received a PREP grant and will contract with Medical College of WI. //2012//

***/2013/ See NPM 8 for PREP update. //2013//***

#### SERVICES FOR CYSHCN

##### Regional CYSHCN Program Collaborations

Five Regional CYSHCN Centers receive MCH Block Grant funds to:

- Provide a system of information, referral, and follow-up services so all families of CYSHCN and providers have access to complete and accurate information.
- Promote a P2P support network to assure all families have access to parent support services and health benefits counseling.
- Increase the capacity of LHDs and other local agencies, such as schools, to provide service coordination.
- Work to establish a network of community providers of local service coordination.
- Initiate formal working relationships with LHDs and establish linkages for improving access to local service coordination.

Core services are information, referral, and follow-up including health benefits services for

families and providers. The emphasis is on the 6 National Performance Measures related to CYSHCN. Regional Centers are actively fostering collaboration with key partners including: cross-referral discussions with Children's Long-Term Care Redesign pilot site; sharing resources with Early Childhood Collaborating Partners (including ECCS); facilitating the spread of Medical Home to local medical practices through the administration of Medical Home Local Capacity Grants and direct team facilitation; offering families with children registered with the WI Birth Defects Prevention and Surveillance Program referral and follow-up services; and cross-referring with WIC Nutritionists. The Collaborators Network continues to expand to include not only the CYSHCN Centers, Great Lakes Inter-Tribal Council, Family Voices of WI, and P2P but also the WIC-CYSHCN Network and MCHB funded CYSHCN Oral Health Project.

WI's CYSHCN Program provides parent support opportunities for families through the 5 Regional CYSHCN Centers, P2P, and Family Voices. As reported for 2009 in SPHERE, centers referred 222 parents to support groups, provided informal parent matching, referred parents to P2P and linked with local parent partners including Family Voices to determine and disseminate parent support opportunities.

Parent to Parent of WI (P2PWI) receives MCH funding to provide one-to-one matching for families, train support parents, and seek referrals for new parents who want to be matched. P2PWI has outreached to providers including those providing services to children newly identified by the Congenital Disorders Program. By 12/09 there were 263 trained support parents in the P2P database and 117 matches. P2PWI translated their curriculum into Spanish, trained non-English speaking support parents and is matching hard-to-reach families in Milwaukee. P2PWI maintains a listserv and Facebook page for support parents.

Family Voices of WI receives MCH funding to build a parent network of informed decision makers, through training, information dissemination and analysis of unmet needs. They disseminate parent support information to parents through a listserv and mailings. Family Voices conducts trainings for parents to enhance their decision making skills and a parent support component is incorporated into these trainings. Family Voices has an MCHB Family to Family Health Information Network which builds on their Title V work and targets hard-to-reach families.

/2012/ CYSHCN Statewide hubs of expertise (Family Leadership, Medical Home, Health Benefits, and Youth Transition) were established as part of the new 5 year grant cycle to augment the work of the 5 Regional Centers and P2P. In collaboration with CHAW, DHS Oral Health Program supports 7 regional oral health coordinators who work with the Regional CYSHCN Centers to provide oral health education and case management to assist families in receiving comprehensive oral health services. Training of over 600 dental health professionals to understand the treatment needs of CYSHCN is ongoing. //2012//

***/2013/ The CYSHCN Collaborators Network brings CYSHCN partners together via phone 3 times per year and holds an annual daylong learning collaborative. //2013//***

#### Statewide Genetics System

Children's Hospital of WI receives MCH funds to support the WI Genetics System. In 2009, the WI Genetics System held outreach clinics throughout the state, educated primary healthcare providers at an annual Genetics in Primary Care conference, worked toward genetic counselor licensure and was active in the Region 4 seven state genetics consortium. The State Genetics Website will be redesigned to give it a more functional capacity as the center of genetic information and resources in WI. Monies will also be provided to the WI Stillbirth Program to update a file system and transfer data because the program recently moved from UW Madison to Marshfield Clinic.

/2012/ Outreach clinics, education of healthcare providers, and work toward genetic counselor licensure continued in 2010 through a contract with Children's Hospital of WI. The newly

designed WI Genetics Website went live June 2010 and activities to promote it are underway. //2012//

***/2013/ In 2012, MCH contracted with 4 institutions to improve statewide education of healthcare providers and the public and supported outreach clinics in 5 cities. The CYSHCN Collaborators Network focused its annual meeting on genetic services to integrate programming and optimize referrals. //2013//***

## Autism

Funds from the Combating Autism Act Initiative (9/08 to 8/11) support the WI Medical Home Autism Spectrum Disorder (ASD) Connections Initiative (Connections) as a State Implementation Grant for Improving Services for Children and Youth with Autism Spectrum Disorder and other Developmental Disabilities and is housed within the CYSHCN Program. This project design uses contracts with key partners including the Waisman Center and the Regional Centers for CYSHCN to strengthen the state's infrastructure and support for families with CYSHCN. Through this work a Community of Practice (CoP) on ASD/DD has been established as an approach to bring together diverse stakeholders from around the state. Parents are central to this work, with two co-chairs who are both parents of children with ASD. Trainings to primary care providers have increased the number of physicians implementing early developmental and ASD screenings. An electronic repository houses Connections resources, links to key websites and a Medical Home Webcast Series. Regional resource mapping is being conducted in the five DPH regions of the state with the outcomes of strengthening collaborations and identifying new resources.

/2012/ This grant ends 8/11 but a sustainability plan details how the work will continue through partner groups. The CoP ASD/DD led by a new steering team (Title V CYSHCN Program, UW-Waisman Center Leadership Education in Neurodevelopmental Disabilities (LEND), and the Autism Society of Southeastern WI). The Regional Core Teams continue with support from the Regional Centers. The Physician Trainings and the Statewide Medical Home continue through MCH LEND. The contact data base and listserv are maintained by the UW-Waisman Center with the educational outreach continuing with WI Surveillance of Autism and Other Developmental Disabilities. The grant has resulted in over 500 new resources shared with state partners, increased capacity of our regional centers to provide timely and accurate information on autism, an increase in physicians trained in developmental screenings and a statewide educational outreach on learning the early signs of developmental delay. //2012//

***/2013/ The CoP ASD/DD led by the steering team (Title V CYSHCN, UW-Waisman LEND, and parent Co-Chair from the NE Regional Center for CYSHCN) hosted 3 statewide meetings. Regional core teams in the Milwaukee area & northeast WI continue to meet and collaborate locally.***

***The contact database and listserv continue to be maintained.***

***The Navigation Guide is available in English and Spanish. //2013//***

## Birth Defects Surveillance and Prevention Program

The WI Birth Defect Prevention and Surveillance Program (WBDPSP) under Statute s.253.12 is required to maintain a birth defects registry of diagnosed birth defects of any WI child age birth up to 2 years of age; requires reporting by pediatric specialty clinics and physicians; protects confidentiality; establishes an advisory council; provides for primary prevention strategies to help decrease occurrence; provides education about prevention of birth defects; develops a system for referrals to early intervention; and has limited service provisions. Funding is \$95,000 annually from a surcharge on birth certificates. Each CYSHCN regional center has designated staff to access birth defect reports from the WBDR. The information is used to assure children with birth defects and their families are contacted and referred to appropriate services

(<http://dhs.wisconsin.gov/health/children/birthdefects/index.htm>).

The WBDPSP currently funds the following prevention initiatives:

- Birth Defects Nutrition Consultant Network (Nourishing Special Needs)
- WI Stillbirth Service Program at Marshfield Clinic Research Foundation
- Women's Health Now and Beyond Pregnancy Project
- Folic acid survey module in the Behavioral Risk Factor Surveillance System survey (biennial).
- A folic acid training module for family planning providers

/2012/ To provide a more seamless system of care for families experiencing a stillbirth, the WI Stillbirth Program St. Joseph's Hospital Marshfield and the Infant Death Center CHAW have outlined a collaborative program plan. //2012//

***/2013/ The 2012 WBDPSP Biennial Report to the legislature is posted on the WBDPSP website at ([www.dhs.wisconsin.gov/health/children/birthdefects/index.htm](http://www.dhs.wisconsin.gov/health/children/birthdefects/index.htm)). Since 2004, the WI Birth Defects Registry (WBDR) has continued to collect information on 87 selected birth defects identified in children from birth to age 2. Between mid 2004 and the end of 2011, 4,891 birth defects from 70 organizations were reported to the WBDR.***

***Cardiovascular birth defects are the most common type of condition. The WBDPSP has focused its attention on reporting through efficient data exchanges.***

***The WBDPSP continues expansion of Nourishing Special Needs Infants and Children and WI Stillbirth Services Program. Both programs have been presented at state and national conferences. //2013//***

## CAPACITY TO PROVIDE CULTURALLY COMPETENT CARE

WI has become increasingly culturally diverse, with an estimated 14% of the population comprising African American, Hispanic/Latino, American Indian, and Asian populations. Numerous studies and reports have documented, including the most recent WI Minority Health Report, 2001-2005, a disproportionate burden of poor health that persists among racial and ethnic minority populations in WI. The report goes on to say that in addition to birth outcomes, "these health inequalities exist for a broad range of conditions, including chronic and communicable diseases...some of these result from differences in the availability of health and preventive services, while others reflect historical and continuing differences in social and economic conditions." The UW Population Health Institute published The Health of Wisconsin, Report Card for July 2007 in which WI received a 'D' for its overall health disparity grade.

WI's Title V Program has a long-standing commitment to promoting culturally competent and linguistically appropriate services, including for its diverse racial and ethnic populations, individuals with disabilities, and families of CYSHCN. The MCH Program promotes the elimination of health disparities as one of its highest priorities, through its partnerships with WI's Minority Health Program, HW2020, and other state and local efforts. Providing services with cultural humility, cultural competency, and linguistic appropriateness have the "potential to improve access to care, quality of care, and, ultimately, health outcomes" (<http://dhs.wisconsin.gov/health/MinorityHealth/index.htm>).

Resources are allocated to meet the unique needs of WI's African American communities. For example, the WI Partnership Program and the University of WI School of Medicine and Public Health have launched a \$10 million initiative--The Lifecourse Initiative for Healthy Families (LIHF)--to investigate and address the high incidence of African-American infant mortality in the state. WI's Title V Program was instrumental in identifying those areas of the state with the highest numbers and rates of African American infant mortality, namely, the 4 communities of Milwaukee, Racine, Kenosha, and Beloit, the communities of focus for this initiative. One MCH Lifecourse Collaborative will be funded in each community and must include a broad range of stakeholders and members, including members of the community to be served. \$200,000 is available for each of the communities of Racine, Kenosha, and Beloit and \$250,000 for

Milwaukee, for this first planning phase. Each collaborative will spend the next 12-18 months developing a multi-year implementation plan to reduce poor birth outcomes and meet the unique needs of the African American families in their communities. Title V managers and staff will continue to provide ongoing guidance for this initiative.

Community collaborations seek to employ community-driven, culturally competent services. One example of a community collaboration is the ABCs for Healthy Families project and recently launched Journey of a Lifetime campaign, funded through the HRSA First Time Motherhood/New Parents Initiative, to improve birth outcomes for African American infants in southeastern WI. Through this grant, we have been able to integrate the life-course perspective into current MCH programs; conduct an innovative social marketing campaign using texting and social networking sites to link women to preconception/interconception, prenatal, family support, and social services in Milwaukee and Racine; and to increase father involvement and support couples transitioning into their roles as new parents.

Focus groups have been conducted and support groups are lead by community facilitators. The project regularly consults with Milwaukee and Racine community advisory boards, and uses community members to conduct surveys, write editorials, and display our materials at conferences. All pictures within our materials are people within our communities, and the name of the campaign was suggested by a community member. We partner with a consultant who is highly committed to involving community members to make this work their own. This project has enabled us to attain a high level of performance in both the family participation and cultural competence MCHB performance measures.

/2012/ HRSA Funding for the ABCs for Healthy Families project and Journey of a Lifetime campaign ended in Nov. 2010. However, other DPH programs, including Diabetes and Tobacco Prevention and Control are using the findings from the focus groups and/or the messages promoting the life-course perspective, in their efforts to improve birth outcomes within African American communities.

Title V continues partnership with the Minority Health Program and its leadership role within DHS to promote culturally appropriate strategies in eliminating health disparities. The Great Beginnings Start Before Birth training provided by Title V staff to Medicaid PNCCs, advocates the understanding and importance of culture and will be required training for the new federal home visiting programs. The WPP, LIHF-funded collaboratives in each of the 4 communities are currently developing their community-driven community action plans and DPH and the Title V program provide TA as needed, including assisting in writing the implementation RFP, and in evaluation of the initiative. //2012//

***/2013/ MCH staff serve on the Minority Health Program Disparities Task Force and participate in a Community of Practice, in its initial stages, to create a department-wide culture dedicated to reducing health disparities. Staff continue to provide expertise and TA in the implementation phase of the LIHF Collaboratives and local project grants, including measures to improve culturally competent care for African American families.***

***PRAMS received funding from the WI Partnership Program to evaluate the LIHF and oversample the southeast portion of WI which has the highest African American infant mortality rate in the state. //2013//***

## **C. Organizational Structure**

Jim Doyle was sworn in as Wisconsin's 44th Governor in January 2003. Governor Doyle considers children a high priority. He believes "that the single most important thing we can do today to ensure a strong, successful future for Wisconsin is to invest in our kids early ... because what we do now will determine what kind of state Wisconsin will be 10, 20, even 50 years from now" (KidsFirst2004). Concurrently, Barbara Lawton was sworn in as Wisconsin's first female

elected Lieutenant Governor. Through her work such as her Wisconsin Women=Prosperity initiative, she has championed women's health issues including Mental Health and postpartum depression.

In 2008, the Governor proposed a Department of Children and Families (DCF) to strengthen the system of services for children and families. The intent was for DCF to unify programs from DHFS and DWD that served the social and financial needs of children and families. This was to assure WI children have opportunities to grow up safe, healthy, and successful in strong families by consolidating programs to strengthen access to and coordination of services. The Governor proposed to implement universal home visiting to all new first time parents and expand targeted home visiting to parents at risk of child maltreatment. Improvements to child welfare included increase the foster care rate, fully fund projected caseloads in Milwaukee County programs, and welfare program staff recruitment and retention. DCF was created with the passage of the budget combining the TANF program, W-2 and the state child welfare systems. On 07/01/2008, the DPH home visiting programs, Family Foundations, and Empowering Families of Milwaukee were turned over to DCF for future administration with MCH support during the transition through 12/31/2010 per MOU. A position accompanied this transition but no MCH funding.

In April 2008, Karen Timberlake was appointed as the Secretary for the DHFS by the Governor prior to the restructuring of the two departments. As of 07/01/2008 with the restructure, came the new Department of Health Services (DHS) formerly the Department of Health and Family Services (DHFS). Within the Department, there was identified six Divisions--Public Health, Long Term Care, Mental Health and Substance Abuse, Quality Assurance, Enterprise Services, and Medicaid which changed its name to Division of Health Care Access and Accountability along with two offices--Office of Legal Counsel and Office of Policy Initiatives and Budget. Official and dated organizational charts are on file in the state office and available on request or accessible via the website at ([http://dhs.wisconsin.gov/organization/435\\_DHS/CoverPage.pdf](http://dhs.wisconsin.gov/organization/435_DHS/CoverPage.pdf)). A brief summary of each division/office follows.

The Office of Legal Counsel (OLC) is an office within DHS which serves the Secretary and acts as a resource for the Department as a whole. The mission of OLC is to provide effective and accurate legal services and advice to the Department.

The Office of Policy Initiatives and Budget (OPIB) provides department wide planning, budgeting, evaluation and county/tribal liaison services.

The Division of Mental Health and Substance Abuse (DMHSAS) develops programs that prevent, postpone, or lessen dependence on mental health/substance abuse services. DMHSAS also ensures quality care and treatment in the Department's institutes and secure treatment facilities.

The Division of Enterprise Services (DES) provides management support related to fiscal services, information technology, and personnel issues.

The Division of Quality Assurance (DQA) certifies, licenses, and surveys approximately 46 kinds of health care and residential programs in the state of Wisconsin.

The Division of Long Term Care (DLTC) oversees the provision of long term support options for the elderly and people with disabilities including the Birth to Three Program. They operate the department institutions for persons with developmental disabilities and handles quality assurance of adult care programs and facilities.

The Division of Health Care Access and Accountability (DHCAA) is responsible for administering programs such as Medicaid, BadgerCare, Food Share, SeniorCare, and disability determination.

The Division of Public Health (DPH) is responsible for providing public health services, environmental and public health regulation. The Division has programs in the areas of

environmental health; occupational health; family and community health including injury prevention, emergency medical services, chronic disease prevention and health promotion; and communicable diseases. It is also responsible for issuing birth, death, marriage, and divorce certificates as well as collecting statistics related to the health care industry and the health of the people in Wisconsin. Coordination and collaboration with other DHS divisions and within DPHs bureaus is expected and regular, especially for particular programs and topic areas such as CYSHCN, teen pregnancy prevention, STIs, tobacco use, child abuse prevention, injury prevention, preconception care, etc.

Dr. Seth Foldy assumed the position as Division of Public Health Administrator in January, 2009. Dr. Foldy was Commissioner of Health, Milwaukee County two years prior to his appointment and had been working on eHealth and incident command related projects prior to his appointment. Dr. Foldy took on restructuring of the Division shortly after his appointment. With the restructuring, 3 (down from 5) bureaus and 2 offices were created. A brief description of each of the bureaus and offices follows:

The Bureau of Communicable Diseases and Emergency Response (BCDER) is responsible for the prevention and control of communicable diseases in Wisconsin and for ensuring that the public health and hospital systems are fully prepared for emergency response whether for bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies. Sections within this bureau include: Emergency Medical Services, HIV/AIDs, Immunization, Communicable Diseases/Epidemiology, STD, Public Health and Hospital Preparedness.

The Bureau of Environmental and Occupational Health (BEOH) promotes public health through statewide programs to increase public awareness of environmental and occupational health hazards and disease and works to prevent and control exposure to environmental and occupational health hazards.

The Bureau of Operations is responsible for the fiscal and budget management as well as the communications within the Division.

The Office of Policy & Practice Alignment (OPPA) develops and implements public health strategic planning. Supports a division-wide planning and policy focus on population health that will result in achieving the goals set out in the state health plans, Healthiest Wisconsin 2010/2020. They work closely with the local public health departments throughout WI providing technical assistance and consultation for Community Health Assessments and Community Health Plans.

The Office of Health Informatics (OHI) collects, maintains and provides vital records for the citizens of the state; integrates and manages major public health related information systems; collects, protects, disseminates and analyzes health care and population-based health data needed to conduct critical state business. It leads Wisconsin's eHealth Initiative.

The Bureau of Community Health Promotion (BCHP) has a primary responsibility to provide a statewide model of integrative public health programming across the life span. The Bureau has key relationships with local health departments, community-based organizations, private voluntary organizations, and academic and health care provider networks.

The BCHP contains four organizational sections: Family Health (includes MCH, CYSHCN, and Injury Prevention); Nutrition and Physical Activity (includes WIC, Food Security, Breastfeeding); Chronic Disease and Cancer Prevention (includes diabetes, cardiovascular/stroke, oral health, arthritis); and Tobacco Prevention. The BCHP has over 100 employees, doubling in size as two bureaus merged together as part of the restructuring plan.

Within the BCHP, the Family Health Section has responsibility for the Title V Program and to

improve the health of women, infants, children including Children and Youth with Special Health Care Needs Program (CYSHCN), teens, and families as they progress through the critical developmental milestones of life and across the lifecourse. A major emphasis of the programs within the Family Health Section involves prevention (including injury prevention and sexual assault prevention), early screening, and early intervention. Examples of the continuum include newborn screening, universal newborn hearing screening, developmental screening early identification of pregnancy. Organization Charts for the Family Health Section and the Bureau of Community Health Promotion can be found in Attachment III.C. - Organization Charts. In addition, a more detailed description including staffing is found in Section III.D.

The Nutrition and Physical Activity Section has responsibility for a variety of public health nutrition education and food programs. WIC (The Special Supplemental Nutrition Program for Women, Infants and Children) and WIC FMNP (Farmers' Market Nutrition Program) provide both supplemental nutritious foods and the critical nutrition information including breastfeeding, needed for healthy growth. TEFAP (The Emergency Food Assistance Program) and CSFP (Commodity Supplemental Food Program) provide USDA commodity foods to low income families. Several nutrition education programs such as the Nutrition and Physical Activity Program, 5 A Day for Better Health, and the Food Stamp Nutrition Education Program to promote healthy eating and physical activity for good health. The Section is also responsible for addressing food insecurity and hunger.

The Chronic Disease and Cancer Prevention Section has responsibility to plan, promote, implement, and evaluate comprehensive population and evidence-based programs using best practices in the following areas: Oral Health, Diabetes Prevention and Control, Cardiovascular Health, Arthritis Prevention and Control, and Comprehensive Cancer Prevention and Control.

The Tobacco Prevention Section has responsibility to reduce tobacco use and exposure in every Wisconsin community. This is accomplished through programs that use best practices to prevent the initiation of smoking by youths and adults, promoting treatment for persons with tobacco-related addictions, and protecting all residents from exposure to environmental smoke.

/2012/ In January 2011, Scott Walker was sworn in as 45th Governor of WI, a Republican who was the Milwaukee County Executive. Shortly thereafter he appointed Dennis Smith as Secretary of the Department of Health Services, with Kitty Rhoades a former Republican legislator as his Deputy Secretary and Kevin Moore as the Department's Executive Assistant. There has been no change in the Department's structure to date. Since October 2010, the DPH has been without a Division Administrator. Sandy Breitborde, Deputy Administrator has been serving in the dual role. No Division structure changes have occurred with the new Department administration. //2012//

***/2013/ In December 2011, Karen McKeown was appointed the Administrator for the Division of Public Health. Ms. McKeown came from the East Texas Medical Center in Tyler, Texas where she was an Oncology Staff Nurse and Manager for 11 years. She oversaw the clinical operations of inpatient and outpatient oncology departments, supervising more than 80 staff members and has worked with physicians and multidisciplinary teams. She recently served as a Graduate Fellow in Health Policy at the Heritage Foundation and as a Student Fellow with the U.S. Senate Finance Committee. Karen graduated from Yale University with her MSN in Nursing Management, Policy and Leadership, 2009; University of Texas at Tyler with a BSN, 2000; and Tyler Junior College with an Associate of Arts degree in 1998. //2013//  
An attachment is included in this section. IIIC - Organizational Structure***

#### **D. Other MCH Capacity**

Wisconsin's current Title V MCH Block Grant award is \$10,823,842. This is Wisconsin's smallest grant award since 1991 (although in 2008 there was a -1.18% reduction to the lowest point of \$10,791,946). Beginning in 1995, the Wisconsin's Title V MCH Block Grant award has steadily

declined (except for slight increases in 1999, 2000, 2002, and 2007 of 1 - 2%). In 2004, we experienced our biggest Title V cut EVER of 5.44% (\$-648,146) with another significant cut in 2006 of 2.67% (\$-299,935). To address the MCH budget reductions, the Department cut state operations by 19% in 2007. During SFY 05, Title V MCH Block Grant supported 46.99 FTEs. For SFY 10, the Grant supports a total of 35.06 FTEs (50 staff). More than 10 FTEs have been eliminated, but the workload and needs continue. Approximately 40% of the Block grant award goes to support State Operations of the MCH and CYSHCN programming (which includes staff at both the regional and state levels). Following is an update of positions that are authorized and funded, respectively, by Wisconsin's Title V MCH Block Grant.

On May 1, 2006, the BCHP implemented a minor organizational realignment. The BCHP Office has ten staff of which 8 (7 FTE) are authorized and funded at some level with Title V funds. (The first number represents the position authority, the number in ( ) represents the amount that is charged to Title V funds, and (C) designates contracted positions.) The Bureau Office consists of the: Bureau Director 1.0 FTE (.25 charged to Title V) Susan Uttech; Chief Medical Officer 1.0 FTE (.75) Murray Katcher; Chief Dental Officer 1.0 FTE (1.0) Warren LeMay ; CYSHCN Medical Director .75 FTE (.75) Sharon Fleischfresser; Health Education Specialist .80 FTE (.80) Mary Gothard; Program Director for Disparities in Birth Outcomes 1.0 FTE (1.0) Patrice Onheiber; State Dental Hygienist Officer 1.0 FTE (1.0) Lisa Bell; and Bureau Office Manager .45 FTE (.45) B.J. Schwartz. The two positions of Youth Policy Director, Claude Gilmore, and Organ and Donor Coordinator, Martha Mallon, have position authority and funding support from other funds (CDC's Comprehensive School Health Program and state GPR and match).

The Family Health Section (office) consists of fifteen staff of which 6 staff (6.0 FTE) are supported with Title V MCH Block Grant funds: Family Health Section Chief 1.0 FTE (1.0) Linda Hale; MCH Unit Supervisor 1.0 (1.0) Terry Kruse; Grants Coordinator 1.0 FTE (1.0) Jayne Vargas; SPHERE Statewide Coordinator and Nurse Consultant 1.0 FTE (1.0) Susan Kratz; Injury and Violence Prevention Coordinator 1.0 FTE (1.0) Becky Turpin, Audiologist 1.0 FTE (1) Elizabeth Seeliger. The other FHS positions include: SSDI--Lorraine Lucinski, Sexual Assault Prevention--Susan LaFlash, SPHERE IS Specialist, Michelle Gainey, Injury Surveillance--Brianna Kopp (C), Congenital Disorders--Tami Horzewski (C), Genetics--Michelle Kempf-Weibel (C), Follow Up Coordinator--Ravi Shah (C), WE TRAC Coordinator--Megan O'Hern (C), Guide By Your Side Follow Through Coordinator--Connie Stevens (C) of which six are contracted (C) positions.

The MCH Unit (which includes the CYSHCN Program) has 11 staff of which 9 staff (9 FTE) are supported with Title V MCH Block Grant funds to include: 2 Public Health Nurses who address infant and young child health 1.0 FTE (1) Ann Stueck (also the ECCS Contract Administrator ) and maternal and perinatal health 1.0 FTE (1) Katie Gillespie; 5 Public Health Educators who address: women's health 1.0 FTE (1) Millie Jones; reproductive health and family planning, 1.0 FTE (1) Mike Vaughn; work of school age and adolescent health is covered by BCHP staff already mentioned, Claude Gilmore, who is funded by other grants, and children and youth with special health care needs 1.0 FTE (1) Peggy Helm-Quest and 1.0 FTE (1) Eden Schafer; 2 Epidemiologists, one dedicated to the MCH Program 1.0 FTE (1) Kate Kvale and 1.0 (1) dedicated to the CYSHCN Program, Liz Oftedahl; and 1.0 FTE (1) Office Associate Laurie Lindquist. The remaining MCH Unit staff include two CYSHCN contracted positions Amy Whitehead and Tim Markle.

The remaining 13.06 FTEs funded with Title V funds within DPH are:

- .32 FTE publications coordinator (Powers) in the Nutrition and Physical Activity Section
- .70 FTE Lead Prevention Consultant (Schirmer) in the Bureau of Environmental and Occupational Health
- 1.1 FTE Fiscal Grants Managers (Lipsey, Stevens, Etten) in the Office of Operations
- 1.0 FTE Policy Coordinator (Wymore) in the Bureau of Health Information and Policy
- 9.94 FTE that provides partial infrastructure support for staff time of regional office directors, nurse consultants, health educators, and nutritionists.

/2012/ The current Title V MCH Block Grant award is \$10,637,979 which continues to support an authorized FTE count of 35.06 (50 positions). Currently we have vacancies of 7 people who have retired or left their positions in the past year. MCH funded positions include Eden Schafer, 1.0 FTE FHS CYSHCN Health Educator; BJ Schwartz, .45 FTE BCHP Bureau Office Manager; Brian Powers, .32 FTE Publications Coordinator in Nutrition and Physical Activity Section, and 2 regional staff, .71 FTE. Non MCH funded but Family Health Section positions include Brianna Kopp, 1.0 FTE Contracted Injury Epidemiologist funded through the CDC Core Injury Prevention and Surveillance Grant and Ravi Shah, 1.0 FTE Contracted Follow-Through Coordinator, funded through the HRSA Wisconsin Sound Beginnings Grant.

The MCH Program was fortunate in October 2010 to have a CDC Maternal and Child Health Epidemiologist assigned to the Wisconsin Division of Public Health. This 1.0 FTE (80% MCH Block Grant funded and 20% CDC funded), filled by Angie Rohan, provides direct assistance to public health agencies and is focused on building MCH epidemiology capacity and applied research. Dr. Rohan provides technical assistance and support to DPH on a variety of MCH data, evaluation, and analytic projects including the analysis of PRAMS data; home visiting evaluation; mentoring of students, fellows, and residents; and the assessment and tracking of disparities in maternal and child health.

BCHP has the .45 FTE vacancy of the Bureau Office Manager but otherwise the authorized FTE count remains at 7 (8 people). The FHS authorized FTE count is 6 (6 people) with the other 9 staff within the Section funded by other federal grant sources. The MCH Unit authorized FTE count is 9 (9 people) with one vacancy, Eden Schafer, CYSHCN Health Educator and the remaining other 2 staff funded by other federal grants. Staff within other areas of the Division of Public Health supported by MCH funding make up 13.06 authorized FTEs. .32 FTE is vacant due to Brian Powers, Publications Coordinator in Nutrition and Physical Activity Section retiring; and the Fiscal Grants Managers have changed although their authorized FTE of 1.1 has not. Currently Sherry Colstad, Sue Beck, and Rosemary Susteren are the staff within the Office of Operations that are supported by Title V funding. And finally the authorized 9.94 FTE providing partial infrastructure support for the regional offices remains the same but as mentioned previously .71 authorized FTEs, or 2 positions are vacant due to retirements. //2012//

***/2013/ The current Title V MCH Block Grant award is \$10,658,234 which is at a similar funding level that Wisconsin experienced 20 years ago in 1992. The number of FTEs supported by these monies remains constant at 35.06 or approximately 50 positions at both the regional and state levels. The Bureau of Community Health Promotion (BCHP) and Family Health Section (FHS) organizational charts (attached) depict current and any vacant positions supported by the MCH Block Grant. The BCHP has 8 people or 7 FTEs funded in part or completely by MCH dollars. The FHS authorized FTE count is 6 which equates to 6 people. The MCH Unit within the FHS has 9 staff or 9 FTE funded. There are 23 authorized FTE or 27 staff within other areas of the Division of Public Health (DPH), both in the central office and the five regional offices that are supported in part or fully by the MCH Block Grant. //2013//***

## **E. State Agency Coordination**

### **COORDINATION WITH MEDICAID**

#### **Prenatal Care Coordination (PNCC)**

The PNCC program assists pregnant women with accessing medical, social, educational and other services during pregnancy through 60 days following delivery. The program consists of outreach, assessment, care plan development, ongoing care coordination and health education. There are PNCC providers in all 72 counties through LHDs; hospitals; health plans and other private non-profit agencies. In 2009 Medicaid worked collaboratively with MCH on guideline revisions for PNCC to support increased outreach, increased intensity of services and improved communication between PNCC provider and medical providers. The program is reaching

approximately 17% of eligible women. PNCC Provider Groups are facilitated by MCH staff in 5 regions for technical assistance (TA) and education. The evaluation of PNCC outcomes using SPHERE data is encouraged. The Women's Health Now and Beyond Pregnancy project was implemented to enhance the PNCC postpartum services to focus on interconception care. Medicaid includes PNCC in the health plan pay for performance initiative with education and TA available from MCH.

/2012/ The MCH Program is working to improve the number of women who receive PNCC services early in pregnancy by providing training and TA to support implementation of PNCC services in local clinics. //2012//

**/2013/ In 2011 9,871 pregnant women received Medicaid PNCC services. MCH is working with Medicaid to revise the PNCC Handbook. //2013//**

#### Health Check

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program in WI Medicaid is known as HealthCheck. HealthCheck promotes the early detection and treatment of health conditions associated with chronic illness or disabilities in children. Medicaid data has demonstrated since 1992 children in HMOs are more likely to receive a HealthCheck exam than children in the Medicaid fee-for-service health reimbursement systems. For FY09, the annual HealthCheck participation rate was 89% with 422,965 screens completed out of 471,447 expected for all children ages birth to 20 years of age eligible for BadgerCare Plus.

/2012/ For FY10, the annual HealthCheck participation rate was 96% with 451,905 screens completed out of 472,189 expected for all children ages birth to 20 years of age eligible for BadgerCare Plus. //2012//

**/2013/ For FY11, the annual HealthCheck participation rate was 98% (462,794 screens completed out of 472,190 expected for all children ages birth to 20 eligible for BadgerCare Plus). //2013//**

#### Medical Initiatives

WI Medicaid intends to contract with 4 managed care agencies in southeast WI for services through 2013. In addition to requiring these HMOs to reach annual performance benchmarks for diabetes testing, blood lead testing, childhood immunization, asthma management, tobacco cessation, emergency department utilization management, and dental utilization, "the organizations will be required to provide coordinated care for pregnant women known to be at high risk for poor birth outcomes." The Title V Program contributed to the specifications for a medical home pilot for high-risk pregnant women, pay-for-performance guidelines, and the formation of a high-risk registry, to facilitate early care and intensive services to women with a history of, or at high-risk for, poor birth outcomes. MCH staff will participate with Medicaid on a workgroup to oversee the implementation and monitoring of these efforts (<http://dhs.wisconsin.gov/badgercareplus/partners/pdf/p-00162.pdf>).

/2012/Work continues on the implementation of the medical home and pay-for-performance (P4P) initiatives. A Healthy Birth Outcomes Care Guide was created as a result of work of the Evidence-based Practices Workgroup (see NPM #18).//2012//

**/2013/See HSI 1A-2B.//2013//**

#### COORDINATION WITH OTHER HUMAN SERVICES PROGRAMS

##### Mental Health and AODA

Governor Doyle's Kids First Agenda of 2005 directed DHS to provide an annual progress report on the implementation of WI's Infant and Early Childhood Mental Health Plan. The DHS Infant Mental Health Leadership Team (IMHLT) formed to integrate infant and early childhood mental health best practices and principles into all programs and services. Areas of collaboration include: Infant Mental Health Endorsement Process; Development and Distribution of Information on Post Partum Depression; WI Infant, Early Childhood and Family Mental Health Certificate program; Project LAUNCH (Linking Actions for Unmet Needs in Children's Health); Standardized Objectives for Screening; and Increasing Screening Practices Within Community Medical Homes.

The Integration of Physical Health, Mental Health, Substance Use and Addiction began through efforts between DPH and Division of Mental Health and Substance Abuse Services. A Joint Statement of Integration and Action Guide were developed to bring public health, mental health, substance use, and addiction disorders together in a conceptual integrated framework to support optimal health across the lifespan. The initiative has moved to the Department level supporting these goals: 1) Decreasing DHS respective program barriers and silos, 2) Reducing duplication of resources and efforts while identifying common areas, and 3) Increasing integration of physical health, mental health, and substance use and addiction services into all systems (<http://dhs.wisconsin.gov/mentalhealth/jointstatement/index.htm>).

MCH staff serves on the WI United for Mental Health Advisory Committee to assure mental illness anti-stigma prevention activities with the focus on racially disparate populations and the workplace. Focus groups of minority women identified that being a woman was more significant in stigma identification than race.

/2012/ MCH staff serves on the Children's Committee of the WI Council on Mental Health which is mandated to advise the Governor, Legislature and DHS on the allocation of Mental Health Block Grant funds. Cross cutting issues include Trauma Informed Care, Seclusion and Restraint, Anti-Bullying, Positive Behavioral Supports, access to Child Psychiatry, Infant Mental Health, Post-partum Depression, Suicide Prevention screening, Transition, Prenatal Alcohol Exposure, parity and continuing access to Medicaid funded services. //2012//

***/2013/ See Needs Assessment for discussion of Adverse Childhood Events. //2013//***

#### Social Services/Child Welfare

The social services and child welfare responsibilities lie within the WI Dept of Children and Families (DCF), a new state agency established in statute on 07/01/09. The mission of DCF is to promote the economic and social well-being of WI's children and families and combines the TANF program, W-2, and the state child welfare systems. DCF is committed to protecting children, strengthening families, and building communities. The child welfare service system in WI is primarily a county-operated, state-supervised system. The State provides program funding and oversees policy direction while county human or social service departments provide child welfare services. Over the past biennium the availability of federal and state funding to county allocations has been reduced.

WI has 11 recognized Indian Tribes that are involved in child welfare services primarily through MOUs with county agencies. Tribes receive funding from DCF for some child welfare services as well as funds directly from the federal government. Two facets of the child welfare system are state operated, including the special needs adoption program for children with special needs and child welfare services in Milwaukee County.

The MCH Program maintains working relationships with DCF and county social services to prevent child maltreatment and promote the health and well-being of children in out-of-home placement. With the transfer of funds for the Child Abuse and Neglect Home Visiting Program to DCF in 2008, a transition plan was implemented for MCH to continue to support DCF in management of the home visiting programs to focus on sustaining program integrity and quality

and to avoid disruption of services. In 2010, DCF hired a home visiting coordinator to manage the home visiting programs and implement changes in allocating funds that addresses the risks for poor birth outcomes.

/2012/ DCF is working collaboratively with many state partners including the State MCH Program to develop the State Plan to meet the home visiting requirements for the Title V evidence-base home visiting program authorized in the Affordable Care Act. //2012//

**/2013/ A home visiting nurse consultant was hired at DHS 1/2012 to continue coordination of DCF-funded (MIECHV) and GPR-funded home visiting programs, working closely with DCF and other partners.**

**A Foster Care Medical Home (FCMH) program is being implemented in Southeast WI in 2012 to offer comprehensive, coordinated services for children in foster care. ([www.dhs.wisconsin.gov/mareform/foster/FosterCareMedicalHome.pdf](http://www.dhs.wisconsin.gov/mareform/foster/FosterCareMedicalHome.pdf)) //2013//**

SSA, Voc Rehab, Disability Determination and Transitions

WI DHCAA Disability Determination Bureau (DDB) determines if WI residents applying for disability benefits meet the criteria for Social Security Disability, Supplemental Security Income, Medicaid, Katie Beckett Program, and Medicaid Purchase Plan. DDB sends names of all new child applicants regardless of eligibility to the CYSHCN program and information is sent to families about the CYSHCN Regional Centers and other resources. Outreach by the Regional Centers includes contact with local SSA and Division of Vocational Rehabilitation (DVR) offices.

DVR, SSA, DPI, and the Regional Centers are youth-to-adult transition stakeholder participants with the State CYSHCN Program in the WI Community of Practice (COP) on Transition. See NPM #06. This COP is a network of individuals and organizations that promotes the successful transition of youth with disabilities and/or special health care needs to all aspects of adult life. The CYSHCN Program through the Regional Centers and DPI support 2 other transition initiatives - Parents in Partnership (PIP) and Youth in Partnership with Parents for Empowerment (YIPPE).

/2012/ The WI Community of Practice (COP) on Transition-Health Workgroup will be incorporating the work from the Autism Community of Practice-Connections Transition workgroup. The CYSHCN Program established a Hub of Excellence on Transition to advance transition care for CYSHCN throughout WI. //2012//

**/2013/ A Medicaid cost savings measure includes a Youth Transition Sustainability Proposal within Family Care ([www.dhs.wisconsin.gov/lcreform/youth-transition.pdf](http://www.dhs.wisconsin.gov/lcreform/youth-transition.pdf)). There are 3 new CLTS waiver codes to facilitate transition experiences for youth. //2013//**

Birth to 3 (B-3)

The Children's Services Section in the Division of Long Term Care (DLTC) is responsible for B-3, the Part C Early Intervention Program, Family Support Program, Katie Beckett Program, Lifespan Respite and 3 Children's Waivers, which include coverage of children with autism. The CYSHCN Program and its Collaborators Network work closely with these programs to coordinate outreach and services to families and providers. The CYSHCN Program and B-3 pool resources to fund First Step, a 24/7 toll-free hotline (includes TTY and language line) and website for parents and providers of CYSHCN. The CYSHCN Program's Early Identification Initiative connects local B-3 programs to primary care providers to promote early referral. Per statute, a B-3 staff is appointed by the DHS Secretary to serve on the Birth Defect Prevention and Surveillance Council. Beginning fall 2009, WSB refers children who are identified as deaf and hard of hearing directly to B-3 via WE-TRAC, the EHDI data collection and tracking system. Beginning in April 2010, the SE Regional Center is part of a pilot program called Compass Wisconsin: Threshold that provides intake, application and eligibility determination for the children's waivers, Katie Beckett, Family Support and Community Options Program. The Regional Center serves families looking for

additional help or services.

/2012/ CYSHCN Program staff serve on the B-3 Interagency Coordinating Council Executive Committee, Child Find Committee (Chair) and Children's Long-Term Support Council. Family Voices and CYSHCN Regional Center staff serve on ad hoc task forces formed to respond to DHS budget proposals. //2012//

***/2013/ CYSHCN staff conducted a webinar for local county B-3 programs on developmental screening outreach efforts and coordination with the Regional Centers for CYSHCN. The Child Find Committee in partnership with the CYSHCN Medical Home hub has drafted a common referral form to be tested with primary care providers and local programs to improve communication. //2013//***

## COORDINATION WITH OTHER FEDERAL GRANT PROGRAMS

### Title X

Family planning services are mandated under the Title X Social Services Block Grant. Agencies receiving Title X funds offer family planning services to clients and provide a list of clinics supported by the WI MCH Family Planning (FP) Program. Community-based health organizations under contract with the MCH FP/RSH/EI Program have established and maintain close linkages with social service agencies for outreach and as a community resource for continuity of care. Some county social service agencies contract with community-based FP/RH programs to support services for low-income uninsured patients who are not eligible for WI's Medicaid Family Planning Waiver (FPW). Many clients are eligible for FPW enrollment and can obtain assistance through local economic support offices often co-located with social service agencies. Community based FP/RSH programs are a source of confidential care for adolescents requiring services to reduce the risk of STDs and unintended pregnancy. Sexual abuse screening is a priority issue addressed as part of adolescent health care. CBOs work closely with local social services agencies on sexual abuse issues.

/2012/ The MCH Program promotes standards of practice and care to ensure consistent quality, comprehensiveness, and timeliness of evidence-based care through all publicly-supported services including Title X family planning services. Family planning services are coordinated with Title X services to provide statewide coverage. The MCH Program provides continuing education, training, and technical assistance to promote uniform practices for STD testing and treatment, cervical cancer screening and diagnosis, and other perinatal and Women's Health Services in Title X programs. Both DPH and Title X jointly participate in and actively support the CDC Region V and State Infertility Prevention Initiative. //2012//

***/2013/ The MCH Women's Health-Family Planning/Reproductive Health Program has responsibility to maintain a statewide system of community-based services. The MCH WH-FP/RH Programs Quality Assurance/Quality Improvement Committee is organized to ensure uniform standards of care in WI community-based programs and to promote the adoption of evidence-based practices in other women's health care settings. //2013//***

### Healthy Start

The Black Health Coalition's (BHC) Milwaukee Healthy Beginnings Project (MHBP) provides prenatal services to African American women in Milwaukee residing in 7 high-risk zip codes and incarcerated pregnant women in Milwaukee. The program collaborates with the community on the Milwaukee Fatherhood Initiative; the City of Milwaukee Health Dept on safe infant sleep; and with DPH Disparities in Birth Outcomes by serving on the Statewide Advisory Committee and the Action Learning Collaborative on Fatherhood. The MHBP brings other providers serving high-risk pregnant women in the Milwaukee area together to collaborate on areas of overlap and identify solutions to fill gaps in services. In 2011 MHBP plans to enhance preconception/interconception

services, expand the service area for prenatal services and improve breastfeeding support for African American women in Milwaukee.

The Healthy Start project with Great Lakes Inter-Tribal Council, Honoring Our Children (HOC), provides MCH nurses, on-site coordinators, and outreach workers at tribal sites for outreach, case management, health education, depression screening and referral, and interconception care for pregnant and postpartum women, infants, children under the age of 2, and their families. Funding from Title V supports expanded HOC services. Project outcomes are documented using SPHERE. SPHERE data is monitored by the tribal sites and used to evaluate and improve the project. MCH staff support the HOC Project through: 1) TA and education related to perinatal health, reproductive health and CYSHCN, 2) participation on the HOC Project Advisory Committee, and 3) participation on the Interconception Care Learning Community team. Representatives from both Healthy Start Projects contributed to development of the Title V Needs Assessment and State Health Plan, Healthiest WI 2020.

//2012/ The MHBP is implementing PNCC and participating in the Southeast PNCC provider group meetings and the Milwaukee Hospital Collaborative. Both Healthy Start Projects in WI are participating in the Interconception Care Learning collaborative and will bring their expertise to the WI Healthiest Woman Initiative forums in 2011. Both projects serve on the MCH Advisory Committee. //2012//

***//2013/ HOC is integrating QI processes and MCH-funded systems building activities focused on child development into their Healthy Start program. The MHBP is working with the Milwaukee LIHF Collaborative to improve fatherhood involvement as part of the community plan to reduce disparities in birth outcomes. //2013//***

#### COORDINATION WITH THE STATE DEPARTMENT OF PUBLIC INSTRUCTION (DPI)

DPI and DHS promote the Governor's School Health Award to improve the nutrition and physical activity of school children as outlined in the WI Nutrition and Physical Activity State Plan for schools. The criteria can be used by schools as a self-assessment tool ([www.schoolhealthaward.wi.gov](http://www.schoolhealthaward.wi.gov)). DPI involves DHS in the development of the physical activity and nutrition questions on the WI Youth Risk Behavior Survey (YRBS) and analysis and interpretation of the data. Data is included in the Obesity, Nutrition and Physical Activity in WI Report (<http://dhs.wisconsin.gov/health/physicalactivity/Dataindex.htm>).

The MCH Program provides ECCS Grant dollars to DPI to support the work of 6 WI Early Childhood Regional Community Coaches in 5 DHS regions and in Milwaukee. The Coaches assist local communities in planning 4-yr-old kindergarten collaborations and provide training and TA on implementation of standards for early learning and to promote development including social-emotional wellness.

DPI is represented on the Sexual Violence Prevention Planning Committee and assisted in developing the goal that recognizes community leaders play both a formal and informal role in preventing sexual violence. Teachers and staff from pre-K through high school have access to information and training on age-appropriate strategies to address violence/sexual violence on WI campuses.

The Guide By Your Side (GBYS) program of WI Sound Beginnings, the state's Early Hearing Detection and Intervention (EHDI) program, is supported by DPI.

DHS and DPI collaborate on statewide and local abstinence, teen pregnancy, STI and HIV/AIDS prevention efforts including the Milwaukee Adolescent Pregnancy Prevention Partnership.

DHS and DPI staff actively lead and participate in the WI Suicide Prevention Initiative (SPI) which maintains the Guidelines for Suicide Risk Assessment. A 2009 Suicide Prevention Summit

identified priorities to develop a statewide infrastructure to support local and community-based suicide prevention coalitions. DHS and DPI drafted model MOU language for community agencies and school districts and collaborated on the development and training of toolkits for suicide prevention and mental health awareness.

The DPI Bullying Prevention Curriculum has sold 5,000+ copies nationwide with DHS support. A Bullying Policy meeting resulted in suggested revisions to guidelines for Bullying Prevention for SB154 requirements.

DPI and DHS participate in the WI School Crisis Preparedness Committee to sponsor the annual School Crisis Preparedness Conference and plan the annual School Safety Week.

DHS and DPI are collaborating with the Minority Health Program to establish a separate chapter on School-Age Youth & Adolescents in the next release of the State Minority Health Report. DPI will work in collaboration with the Nutrition and Physical Activity Program to develop its Disparity Report. The feasibility of establishing a joint department Task Force to address needs of the LGBT population in relation to their high disparate burden is being explored.

/2012/ In 2010, DPI, in partnership with DHS and UW-Madison School of Medicine and Public Health, created the WI Active Schools Project as part of the Communities Putting Prevention to Work initiative funded under ARRA. The Project will increase options for physical activity in schools and school-linked settings to help young people achieve 60 minutes of daily activity in 21 schools and 26 community coalitions. The Governor's School Health Awards gave \$16,000 of ARRA funds to 21 WI schools.

Through a joint effort, DHS and DPI created and published the "WI Youth Sexual Behavior and Outcomes: 2000-2009 Update: Sexual Behaviors: Cases of STD and HIV, and Teen Births" ([www.dhs.wisconsin.gov/aids-hiv/Stats/09YouthSexBehaviorUpdate.pdf](http://www.dhs.wisconsin.gov/aids-hiv/Stats/09YouthSexBehaviorUpdate.pdf)).

In 2010, DHS, DPI and DCF state agency partners were awarded a 5 year federal Personal Responsibility Education Grant (PREP) to increase abstinence, prevent teen pregnancy and improve opportunities for youth transition to adulthood. Project activities will be implemented in 3 WI cities with the highest rates of teen births. //2012//

**/2013/ DPI and DHS collaborated on the development of the 2011 WI YRBS**  
**(<http://dpi.wi.gov/sspw/yrbsindx.html>).**

**DPI serves on the State PREP Grant Advisory Committee and on a DPH LGBT Task Force.**  
**DPI is developing new high school lessons and a K-3 curriculum on bullying.**  
**Work continues on a separate school-age youth and adolescents chapter of the State Minority Health Report. //2013//**

#### COORDINATION WITH FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

The MCH Program worked with Milwaukee Health Services, Inc. to implement group prenatal care, Centering Pregnancy and group pediatric care, Centering Parenting. The initial outcomes have shown a 96% rate of term births; 96% child spacing of 12 months; 50% breastfeeding initiation. The MCH Program assisted with providing a Father Circle simultaneously with the Centering Pregnancy.

The CYSHCN Regional Centers worked with select community health centers and their primary care providers to establish resource and outreach materials for Latino families and promote Medical Home implementation including developmental screening. The CYSHCN Program worked with the Primary Care Assn on access to health and dental care for individuals with disabilities as part of a series of Disabilities and Disparities regional meetings led by the Division of Long Term Care.

Currently, 14 of 17 FQHCs provide direct preventive and restorative dental care at 26 delivery sites throughout WI. Several of these agencies are specially equipped to meet the unique needs of CYSHCN. In addition 43 dental professionals in 4 FQHCs received didactic and clinical training to increase and enhance their knowledge and skill base as it relates to treating CYSHCN. This training is being replicated in WI FQHCs as a result of a HRSA grant award.

/2012/ Milwaukee Health Services, Inc. expanded Centering Parenting, developed an Obstetrical Medical Home, expanded PNCC services at 2 clinics and received PNCC training and technical assistance by Title V staff. //2012//

***/2013/ Project LAUNCH and the WI Medical Home Initiative provided training on developmental screening to Milwaukee Health Services.  
In 2011, 2 Milwaukee based FQHCs participated in the Medicaid HMO OB Medical Home Pilot. //2013//***

## COORDINATION WITH UNIVERSITIES

The MCH/CYSHCN Programs coordinate with the UW School of Medicine and Public Health, Nursing, Population Health, and Waisman Center on program activities such as: UCEDD/LEND on early identification and Autism Spectrum Disorders Connections Initiative, EHDI learning collaborative, and Pediatric Pulmonary Center on youth with special needs transitions. The Oral Health Program partners with the Marquette Dental School and 2 technical colleges to improve dental access and provide training. Title V provides student mentoring for pediatric and family medicine residents, fellows, MPH students and undergraduates. The UW Extension system is a partner in training and education. Relationships exist with the State Laboratory of Hygiene, Medical College of WI, the Schools of Nursing at UW-Milwaukee and Marquette, the UW-M School of Communication, and technical schools on topics such as oral health, perinatal care, family planning, home visiting, medical home, birth defects surveillance and prevention, and early hearing detection and intervention.

UW-Madison School of Nursing received funding from HRSA since 10/06 for the Linking Education and Practice (LEAP) for Excellence in Public Health Nursing Project. LEAP is implemented in partnership with other WI Schools of Nursing and DPH. The purpose of LEAP is to improve competency for public health nursing practice by educating public health nurses, student nurses, and nursing faculty in the knowledge and skills required for providing population-based, culturally competent public health nursing services. A focus is on competencies to provide services to MCH populations.

Developed in part with ECCS funds and through leadership of the MCH Program, the UW Infant, Early Childhood and Family Mental Health Certificate Program-Foundations Certificate was developed as the pathway within a 1 year program intended for professionals from multiple disciplines who seek professional development in providing infant and family consultation and relationship-based services to young children and their families within the context of reflective practices. The training begins 6/10. ([www.dcs.wisc.edu/pda/mental-health/infant.htm](http://www.dcs.wisc.edu/pda/mental-health/infant.htm))

The conversion of Blue Cross/Blue Shield of WI to a for-profit corporation led to establishment of an endowment fund for public health purposes. Community and academic partnership projects are funded through the UW School of Medicine and Public Health and Medical College of WI. MCH projects have been well-represented among grant award winners in both medical schools' grant competitions.

/2012/ The UW School of Medicine & Public Health Partnership fund doubled their contribution to the Healthy Birth Outcomes Program from \$10 million with a promise from the UW Foundation to raise an additional \$10 million match. The Oral Health Program partners with the Marquette University School of Dentistry and 4 technical colleges to improve dental access, prevention based services and a culturally competent diverse dental public health workforce through a

multidisciplinary provider training. The MCH/CYSHCN Programs are part of the MCH Partner Group that includes other MCHB funded projects that meet regularly to coordinate activities. The CYSHCN Program created the Integrated Management Team that includes UW UCEDD/LEND to coordinate physician outreach and training activities around early identification of special needs. In 2011 this group is developing a data base to track activities by provider. //2012//

***/2013/ A UWSMPH MD/MPH student and MPH fellow work on reducing disparities in birth outcomes and the WI Healthiest Women Initiative. The CYSHCN Program continues a strong partnership with the UW Waisman including shared staffing. MCH/CYSHCN are part of the MCH Partner Group with MCHB funded state partners at universities.***

***WI Sound Beginnings partners with the UW-Madison Audiology Program to provide early head start children hearing screening. //2013//***

## **F. Health Systems Capacity Indicators**

Health Systems Capacity Indicator 01: The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.

The WI DHS conducted asthma surveillance activities since 1992 and asthma interventions since 1994. The WI Asthma Coalition has 310 members and 10 local asthma coalitions. CHAW coordinates the coalition and Plan. DHS conducts asthma surveillance. The updated Wisconsin Asthma Plan 2009-2014 (WAP) was approved by the DHS Secretary and the WI Asthma Coalition in May of 2009 (<http://dhs.wisconsin.gov/eh/Asthma/pdf/WACPlan20092014.pdf>). The goals of the plan are to:

- Expand and improve the quality of asthma education, prevention, management and services.
- Decrease the disproportionate burden of asthma in disparately impacted populations.

Individuals with asthma are disproportionately affected across age categories, gender, race and ethnicity, geographic regions and socio-economic status. Wisconsin children experience a gradual increase in lifetime and current asthma prevalence. Asthma ED visit rates have remained steady at approximately 40 visits per 10,000 individuals per year. However, children aged 0-4 years had the highest asthma ED visit rate (72 visits per 10,000 in 2009). Asthma hospitalizations among children aged 0-4 declined from 43.4 per 10,000 in 1990 to 21.6 per 10,000 in 2009, however they have the highest asthma hospitalization rate compared to other age groups. Males are more severely impacted by asthma during childhood, while females are disproportionately affected after puberty. While hospitalization rates for which asthma was the principal diagnosis have decreased between 2004 and 2009, rates for which asthma was an underlying diagnosis have increased. Reasons for this increase are unknown, but may be due to an increase in asthma prevalence, changes in billing or coding, or other factors. Asthma hospitalization rates in WI are five times higher in African Americans and two times higher in Native Americans, compared to whites (37.1 and 12.4 versus 6.9 per 10,000 in 2009). In 2009, Milwaukee County and Menominee County experienced the highest county-specific rates of asthma hospitalizations in WI.

Asthma surveillance remains a priority. Surveillance data continue to demonstrate that Milwaukee and Menominee Counties have the highest rates for ED utilization, and high rates of inpatient hospitalization for asthma. The following programs address these issues.

FAM Allies: Milwaukee County ranks second among counties for asthma hospitalization rate (21.0 per 10,000 population, 2003-2005), and has the highest hospital ED visit rate (96.3 per 10,000 population, 2003-2005) in the state. In 2011, the Children's Hospital and Health System (CHHS) ED saw 250 patients with a diagnosis of asthma, and the Wheaton Franciscan/St. Joseph's (WFSJ) ED saw 1,789 patients with a diagnosis of asthma. To support these ED patients, FAM Allies plans to develop new ED protocols to systematize related recommendations of the NAEPP guidelines.

Menominee Tribal Clinic: In order to address the high level of uncontrolled asthma in the Menominee Tribal Clinic's asthma patients, an asthma assessment form and an education tracking form developed in conjunction with DHS' evaluation specialist will be used. These forms have become incorporated into the clinic's EMR.

American Lung Association in Wisconsin: As a means to increase/maintain the number of certified asthma educators in WI, the Lung Association will offer the Asthma Educator Institute.

Children's Health Alliance of Wisconsin: The Children's Health Alliance of WI will continue to coordinate WAC and meetings and webinars; integrate partnership activities, including collaboration on the Radio News Network's asthma topics; facilitate the maintenance and implementation of the WI Asthma Plan 2009-2014 and coordinate the local asthma coalitions.

In conjunction with staff from DHS, WAC will develop and implement a template adaptable to any health care system to facilitate follow-up plans for asthma patients who over-utilize emergency asthma care services. Currently no statewide process or template exists and therefore efforts will be focused on a template that can be implemented statewide and focused in areas with the highest burden of asthma. A total of ten local asthma coalitions have become WAC member coalitions.

Other activities: Asthma Care Fax; School walkthrough program; Home walkthrough program; Asthma Focused Follow-up Visit and Asthma Control Test; Replication of the emergency department referral and follow-up programs.

Health Systems Capacity Indicator 02: The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen; and Health Systems Capacity Indicator 03: The percent State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

BadgerCare Plus is a combination of WI Medicaid Program for families and the State Children's Health Insurance Program (SCHIP). Since February 2009, all children under 19 years old at all income levels can enroll in BadgerCare Plus. Children under the age of 1 in WI fall under the Medicaid, and not the SCHIP, portion of BadgerCare Plus.

HSCI 2 aligns directly with Wisconsin's priority to increase the number of women, children, and families who receive preventive screenings, early identification, and intervention. Identification of health risks and concerns as early as possible in the lifespan, during developmentally sensitive periods yields the greatest benefits for optimal health. WI has shown some consistency in this indicator, with more than 90% of Medicaid enrollees under one year of age receiving at least one initial periodic screen. Since the enactment of the BadgerCare Plus program, the percent of Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen has remained high. In SFY 2011, 89.3% of these infants received a screen. Although that proportion was slightly lower than the 92.1% reported for SFY 2010, a larger absolute number of infants on Medicaid were reported to have received an initial periodic screen (35,708 vs. 32,441). A shift was observed in the numbers reported for HSCI 2 and HSCI 3 between 2008 and 2009; this was due to a change in the data contractor for the Medicaid program and their methodology used to calculate the indicators. Due to this change, we continue to closely monitor these data closely with our Medicaid partners.

We continue to strive for improvement in this indicator, and a number of recent initiatives may help to increase the numbers in the coming years. These include:

- Act Early, Learn the Signs
- WI Statewide Medical Home Initiative training of primary care providers on the ASQ 3 and M-CHAT.

- Education and promotion of early screening through the MCH Program, Project LAUNCH, the Family Foundations home visiting program, ECCS, and the Governor's Early Childhood Advisory Council.

More detail on some of these efforts is included in the narrative for SPM 6.

Health Systems Capacity Indicator 04: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index; and

Health Systems Capacity Indicator 05D: Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])

Per the Wisconsin Interactive Statistics on Health the overall percentage of women with a live birth with adequate prenatal care is 84% for the total population. While the indicator is good overall, evidence of racial and ethnic disparities are reflected in black/African American women (74%); Laotian/Hmong women (66%); Hispanic/Latina (75%); and American Indian (75%). Wisconsin PRAMS tells us that overall 13% of women report not being able to get into prenatal care as early in their pregnancy as they wanted. Of those, 10% were White, 23% were Black, 19% were Hispanic, 21% were Non-Hispanic Other.

Looking at the proportion of women receiving early prenatal care from 2000-2010 the greatest increase has occurred with the Laotian/Hmong (47% to 66%) women and the Hispanic/Latina (68% to 75%) women, while there has been little to no change with the black/African American (70% to 74%) women and the American Indian (72%) women.

The Wisconsin Department of Health Services identifies early and consistent access to quality prenatal care essential to improving and reducing disparities in birth outcomes. See Health System Capacity Indicators 05, A, B, C for action steps

Health Systems Capacity Indicator 05A: Percent of low birth weight (< 2,500 grams); and  
Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births; and  
Health Systems Capacity Indicator 05C: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

Per the Wisconsin Births and Infants Deaths, 2010 the disparity between the black/African American (13.8) and white (6.2) low birthweight rates has lessened. This is not because the black/African American rate has improved but because the white low birthweight has increased. This was not the case when looking at infant mortality, where the disparity ratio between black/African American (13.9) rate to the white (4.9) infant mortality rate increased from 2.2 to 2.7 from 2008-2010. When looking at prenatal care the overall proportion of women receiving first trimester prenatal care was 84% in 2010. However, the proportion of black/African American women receiving first-trimester care was 74%, which is an increase from (70%) in 2000. While these indicators identify some improvement in the black/African American infant mortality rates in recent years they have remained highest. Other noticeable trends are: 1) the increase in low birthweight infants (8.3%) to other Asians. This may be related to an increase in Burmese and Bhutanese refugee immigration to WI starting in 2008; 2) the increase in first trimester prenatal care for Laotian/Hmong (66%). This may be due to increased access to prenatal medical care through Badger Care Plus, Medicaid for pregnant women; and 3) The decreased infant mortality rate for Hispanic/Latino (4.4 deaths per 1,000) compared to white (4.9 deaths per 1,000). This may also be due to increased access to prenatal medical care through Badger Care Plus.

The WI Department of Health Services continues to identify reducing poor birth outcomes (low birth weight and infant mortality) as a priority. Because the African American has the highest disparity among all racial and ethnic populations in Wisconsin, our efforts will continue to primarily focus on this population. However, there are efforts at the local level by health departments in Madison and Milwaukee to increase the awareness in the medical community of the known

nutritional deficits of refugee Burmese and Bhutanese pregnant women. Action steps for these indicators include: 1) continue to work with Medicaid on the Healthy Birth Outcomes Medicaid Pay for Performance initiative and the HMO Medical Home Pilot for High-Risk Pregnant Women to expand to other communities with higher rates of poor birth outcomes; 2) maintain the effort to expand the MCH Keeping Kids Alive initiative in collaboration with CHAW, to integrate FIMR and CDR in LHD jurisdictions to monitor and evaluate trends in poor birth outcomes at the local level and implement recommendations for change; 3) expand the Wisconsin Healthiest Women Initiative to promote system level efforts to improve the health of women and men before pregnancy and send uniform messages on health across the lifespan; and 4) collaborate with Medicaid to increase quality outreach in high risk communities for PNCC services and to improve PNCC provider skill with working with 'hard to reach' families. For more information see IIIA. Overview: ELIMINATING RACIAL AND ETHNIC DISPARITIES IN BIRTH OUTCOMES

Health Systems Capacity Indicator 06A: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1); and  
Health Systems Capacity Indicator 06B: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children; and  
Health Systems Capacity Indicator 06C: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women

As of 2008, the term "BadgerCare Plus" replaced the programs previously known as Family Medicaid Healthy Start, and BadgerCare in Wisconsin. BadgerCare began as Wisconsin's SCHIP program. Before BadgerCare Plus, income eligibility levels, in terms of percentage of the federal poverty guidelines (FPL), were within 185% of FPL for infants, children to age 18, and pregnant women. Families could remain insured in the program while earning up to 200% of FPL

With BadgerCare Plus, these populations, and their income eligibility levels, were implemented:

1. All children, (birth to age 19,) with incomes above 185% of FPL;
2. Pregnant women with incomes between 185 and 300% of FPL;
3. Parents and caretaker relatives with incomes between 185 and 200% of the FPL;
4. Caretaker relatives with incomes between 44 and 200% of FPL;
5. Parents with children in foster care, with incomes up to 200% of FPL;
6. Youth ages 18 through 20 aging out of foster care; and
7. Farmers and other self-employed parents with incomes up to 200% of FPL, contingent on depreciation calculations.

Currently, according to the Frequently Asked Questions on the DHS website, the following individuals may be eligible: ([www.badgercareplus.org/faq.htm](http://www.badgercareplus.org/faq.htm))

- All children under age 19, regardless of income.
- Pregnant women with incomes up to 300% of the Federal Poverty Level (FPL).
- Parents and relatives caring for a child up to 200% of the FPL.
- Young adults in foster care who turn 18 on or after January 1, 2008, will automatically be able to get BadgerCare Plus until they turn 21, regardless of income.
- Farm families and other families who are self-employed may be eligible under BadgerCare Plus if their income is under 200% of the FPL. BadgerCare Plus has a new way of counting depreciation which will help more families enroll.
- Parents whose child/children are in foster care and you have a reunification plan in place may be eligible for BadgerCare Plus if their income is below 200% of the federal poverty level.

The scope of coverage under BadgerCare Plus is such that virtually all of pregnant women, infants and children receive "standard" coverage equivalent to Wisconsin's comprehensive Medicaid benefit package. BadgerCare Plus represents the most sweeping expansion and reform of the low-income, family portion of Medicaid since its inception in 1966. Wisconsin will streamline eligibility, assist employees to purchase quality, employer-sponsored coverage, and provide incentives for healthy behaviors.

In 2009, Wisconsin implemented an expansion to cover childless adults with a Core Plan of more limited benefits. That program, subject to federal budget neutrality provisions, quickly reached its enrollment limit. In the 2010 Legislature, a proposal to implement a self-funded Basic Plan for those on the sizable Core Plan waiting list was enacted into law. The Legislature approved the Basic Plan, which BadgerCare Plus officials hope will serve as a "bridge" to the more comprehensive coverage options offered by the enactment of national health systems reform. The BadgerCare Plus Basic plan is an optional, limited benefit health care plan. Only individuals who are on the Core Plan Waitlist will have the option to enroll in the Basic Plan. Enrollment in the BadgerCare Plus Basic on June 1 with benefits to begin July 1. All members must pay a monthly premium of \$130 per person.

In 2011, no changes enacted that affect Medicaid or SCHIP (BadgerCare Plus) eligibility for infants, children, or pregnant women. However, the Governor established an Office of Free Market Health Care to develop a plan for the design and implementation of a Wisconsin Health Insurance Exchange and asked for stakeholder comments.

As of January 2012, Wisconsin's Governor announced he will not pursue the implementation of a health insurance exchange, turned down Early Innovator Grant funding from the federal government, and to repeal the executive order that created the Office of Free Market Health Care. In addition, according to a January 26, 2012 memorandum by the Legislative Fiscal Bureau, "DHS has estimated that if all of the changes requested in the Medicaid 2014 Waiver request were approved, approximately 29,100 children would no longer be enrolled in the program, either because they would no longer be eligible, or because their families would disenroll them in response to the higher premiums proposed under the waiver request. In addition, DHS has proposed requiring almost all BadgerCare Plus recipients with family income between 100% and 200% of the FPL to switch from the Standard Plan to a new Alternative Benchmark Plan, which would have more limited benefits and substantially increased cost-sharing requirements compared to the Standard Plan. It is not known how or when CMS will respond to these still-pending items.

([http://legis.wisconsin.gov/lfb/publications/Miscellaneous/Documents/2012\\_01\\_26\\_WILeg\\_MA.pdf](http://legis.wisconsin.gov/lfb/publications/Miscellaneous/Documents/2012_01_26_WILeg_MA.pdf))

Health Systems Capacity Indicator 07A: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

Effective April 1, 2009, Wisconsin Medicaid broadened the requirements for Express Enrollment for children to allow more children to enroll. Previously, Express Enrollment for children was limited to children 18 years or younger with a family income at or below 150% of the FPL. The change allowed children who meet the following criteria to temporarily enroll in BadgerCare Plus via Express Enrollment and receive health care coverage under BadgerCare Plus while a full application is being processed by their local county or tribal agency: children younger than age 1 whose family income is at or below 250% of the FPL, children ages 1 through 5 whose family income is at or below 185% of the FPL, and children ages 6 through 18 whose family income is at or below 150% of the FPL.

Since the enactment of the BadgerCare Plus program, the percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program has remained high. In Wisconsin State Fiscal Year 2011, it was reported that 85.9% of potentially-Medicaid eligible children received a service paid by the Medicaid program; this was similar to, but slightly lower than, the 89.9% reported for SFY 2010. As with other Medicaid indicators, the trend for this indicator is interpreted cautiously because of recent changes with Medicaid data contracting and reporting.

Starting in January 1, 2012, all income maintenance (IM) services (including Medicaid) are provided by county agencies that are part of a consortium. These consortia are intended to work together to improve the way individuals and families receive help from their agency when

applying for benefits or managing their benefits, increase efficiencies within the IM system, and help save money. We will continue to monitor this indicator to identify what, if any, impact these administrative changes have on the data. We also continue to identify opportunities to connect eligible children (and their mothers prenatally) to Medicaid enrollment and services, including through home visiting programs and through improved outreach as proposed in Wisconsin's Strong Start application to the Center for Medicare and Medicaid Innovation.

Health Systems Capacity Indicator 07B: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

The problem of finding dental providers willing to accept Wisconsin Medicaid continues. Medicaid reimbursement for dental providers additionally presents access problems. The Medicaid reimbursement rate for dental professionals, although varies widely from state to state, is typically much lower than private pay patients and doesn't cover office overhead costs associated with treatment.

Wisconsin is working aggressively to increase capacity, especially in community health centers (CHCs) and safety net clinics, recently awarding \$850,000 to nine non FQHC safety net dental clinics. These clinics are geographically diverse with one awarded clinic in each of the five designated state public health regions. Awards were primarily to support expanded infrastructure including staffing and capital equipment expenses. Wisconsin has demonstrated a commitment to increasing access to dental care through the safety net dental clinic by including these grant funds as a biennial budget allocation.

There is a declining dental provider population with more dentists reaching retirement and a short supply of new dental graduates. This disparity makes it a challenge for patients to obtain appointments, as well as for communities to retain dental providers. The WI Office of Rural Health has consistently increased their dental recruitment rates from 10 in 2006 to 15 in 2009, and 18 in 2011, with most placed in CHCs.

WI is unique in that dental Medicaid reimbursement is both fee-for-service and HMO. The HMO's who service the largest portion of WI Medicaid recipients in and around Milwaukee typically have lower utilization than those in fee-for-service. In 2010, 2 additional counties in SE WI were included in the HMO service area. WI is working on a mechanism for more comprehensive accountability on the part of the HMO administrator. The WI Division of Health Care Access and Accountability (DHCAA) has instituted strategies to assist enrollees in connecting with providers. Notably, DHCAA has increased capacity of their member services department to include 2 additional Ombuds who work with enrollees. Dental utilization for EPSDT children between 6-9 years of age in the four counties serviced by the HMO in 2010 is 46.6%, an increase over past years.

Wisconsin has seen an overall marked increase in dental services provided to all Medicaid enrolled children. In FY 2010, 23,803 children 6-9 years of age received a dental service. Of those children over 21,000 received a preventive service and 7,000 received at least one dental sealant on a permanent molar. Wisconsin continues to direct resources and programming to reach children most in need.

Health Systems Capacity Indicator 08: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

As of December 2011, 18,499 Wisconsin children under the age of 16 received SSI benefits per being automatically eligible for the Wisconsin Medicaid Program, which provides comprehensive rehabilitative services to children. Results from the 2009-10 NS-CSHCN indicate that about 8% of all CSHCN nationwide receive SSI benefits. In Wisconsin, 8.4% of these children receive SSI benefits. The CYSHCN Program provided information and resource materials (i.e. CYSHCN

Regional Centers, Family Voices, Birth to 3, and other disability resources) to 2,764 families who made application to SSI whether or not the child was found eligible for SSI. This is made possible through a formal MOU agreement with the Wisconsin Social Security Administration Office. Under this agreement, the Wisconsin Disability Determination Bureau of SSA electronically provides the State CYSHCN Program names and addresses of children under age 16 who have made application for SSI benefits.

Direct services were provided to 173 recipients less than 16 years of age through MCH programs and the CYSHCN Regional Centers.

The denominator, 18,499 is provided by the Social Security Administration (SSA) through an agreement between SSA state level summaries of these data are made available for dissemination to state, regional and national programs services serving CSHCN. The numerator is the same as all SSA recipients in Wisconsin are automatically eligible for the Wisconsin Medicaid Program of which provides comprehensive therapy and rehabilitative services. This indicator is consistent with other states with universal Medicaid coverage for these services. Title V's role is focused on assuring families are aware of and enrolled in SSI and then in obtaining Medicaid benefits and services as applicable.

Health Systems Capacity Indicator 09A: The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.

The Wisconsin Title V MCH/CYSHCN Program has access to policy and program relevant data from several sources, including:

- Birth records are matched to infant death certificates;
- Birth records are linked to both Medicaid eligibility and infant hospital discharge files; Birth records are not linked to MA paid claims on a regular basis but have been linked for special projects;
- Birth records are not linked to WIC eligibility files but have been linked to WIC Pregnancy Nutrition Surveillance System (PNSS) and WIC Pediatric Nutrition Surveillance System (PedNSS) files through 2002 births. These have not been linked in recent years because of funding limitations;
- Birth records have been linked to newborn screening files on a pilot basis and for special projects, but are not currently linked routinely. The Wisconsin Vital Records reporting system upgraded to the 2003 birth certificate revision and an on-line electronic system in January of 2011; the newborn screening blood card ID is now included on the birth certificate to allow for easy linkage of these data systems;
- Hospital discharge survey data for in-state discharges, as well as Minnesota discharges of Wisconsin residents;
- Wisconsin Birth Defects Registry (WBDR) which allows for real-time reporting of birth defects electronically either as individual reports or by uploading from an electronic records system to a secure website;
- Data from the PRAMS survey (2007-2009) are now readily available, with the newest year of data (2010) to be ready for analysis in the summer of 2012; and
- Data from the Behavior Risk Factor Survey (BRFS) and Youth Risk Behavior Surveillance System (YRBSS).

In addition to the above data sources, Wisconsin MCH Program's internal data collection system, the Secure Public Health Electronic Record Environment (SPHERE) system continues to document and evaluate standardized demographic and health information, health status indicators, and outcomes of MCH activities. SPHERE documents and has reporting ability to evaluate maternal and child health activities and interventions at the individual, household, community, and system level and is used to track selected services and outcomes related to the NPMs and SPMs. SPHERE has been selected as the primary data system for Wisconsin's Family Foundations home visiting initiative. Wisconsin's MCH Program has been actively involved in the design of proposed data systems to inform early childhood programs and policies

in the state, including the Newborn Health Profile Project and an inter-departmental effort with the Department of Children and Families and the Department of Public Instruction to create an early childhood longitudinal data system.

The Wisconsin MCH Program has also been actively working to increase its capacity for data analysis. The state has successfully competed for 3 MCH Applied Epidemiology fellows (2008-2010, 2010-2012, 2012-2014), and in 2010 a CDC MCH Epidemiology Assignee was assigned to Wisconsin. The MCH Program epidemiology staff also participate in a Division of Public Health working group which aims to improve staff collaboration and capacity around data analysis.

Health Systems Capacity Indicator 09B: The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.

The Bureau of Community Health Promotion's (BCHP) Tobacco Prevention Section has responsibility to reduce tobacco use and exposure in every Wisconsin community. The section analyzes the YRBS tobacco questions on a regular basis and administers the WI Youth Tobacco Survey every other year. BCHP staff work closely with Wisconsin DPI staff and are actively involved in the YRBS analysis and dissemination of results.

## **IV. Priorities, Performance and Program Activities**

### **A. Background and Overview**

The attached grid (see Attachment IV.A) depicts the National and State Performance Measures, their objectives, and the most recent indicators. We have noted whether or not we have met the objective. The following narrative sections include discussion on Wisconsin's ten state priorities (Section IV.B), the national performance measure activities (Section IV.C), and state performance measure activities (Section IV.D).

***An attachment is included in this section. IVA - Background and Overview***

### **B. State Priorities**

The priorities of the Wisconsin MCH Program for 2011-2015 differ slightly from previously identified priorities because of the MCH Program's increased emphasis on life-long prevention, increased understanding of the social-ecological model of health improvement and recent research on the life course theory. The eight priorities are not specific risk or protective factors, but identify key areas to support and implement interventions that will target a myriad of factors as early as possible while acknowledging the role of families, the health system and communities on the risk and protective factors impacting an individual's health.

The priorities of the Wisconsin MCH Program for 2011-2015 are:

- a) Reduce health disparities for women, infants, and children, including those with special health care needs

Wisconsin's racial and ethnic minority communities continue to endure striking inequities in health. Social, environmental, cultural, and economic factors, including poverty, education, use of health care, health literacy, and quality of health care exert considerable influence on the health of mothers, children, and families. In addition, children and youth with special health care needs experience differences in health outcomes compared to other children.

This priority focuses on promoting activities and policies that reduce health disparities for women, infants, and children, including children with special health care needs. By identifying and addressing differences in health outcomes, the Wisconsin Maternal & Child Health Program expects efforts to promote health equity and reduce disparities will result in social environments and public policies that lead to changes in:

NPM #04 Percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.

SPM #01 Percent of African-American women having a live birth who experience depressive symptoms after pregnancy.

HSI8a. and HSI8b. Numbers of children's deaths by race and ethnicity.

Outcome Measure: The ratio of black infant mortality rate to white infant mortality rate.

Additional Measures: Disparity Ratios for infant mortality, low birth weight (<2,500 grams), prematurity and timing of entry into Women, Infants & Children (WIC) Program, and racial and ethnic disparities in teen birth rates.

- b) Increase the number of women, children, and families who receive preventive and treatment health services within a medical home

Receipt of preventive and treatment services within a medical home model leads to better health

outcomes. Services such as primary care, prenatal care, well-child and well-women care are most effective if provided by a medical home that knows its patients and patient populations; partners with and learns from patients and families; connects with other community-based organizations; and offers safe, efficient care while coordinating with other medical providers such as reproductive and mental health providers. (Wisconsin promotes the right of all men and women to receive sensitive and personal health related services from a separate medical home including reproductive/sexual health and mental health as part of the larger patient centered care approach described in the context of the "medical home" concept.)

This priority focuses on promoting activities and policies that support the development of medical homes and contributes to the overall health of women, children, and families. By emphasizing this comprehensive approach to coordinated care, the Wisconsin Maternal & Child Health Program expects efforts to promote medical homes will result in health care environments and public policies that lead to changes in:

NPM #03 Percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.

SPM #02 Percent of children who have a medical home.

Additional Measures: The number of certified medical home practices in the state according to NCQA.

c) Increase the number of children and youth with special health care needs and their families who access necessary services and supports

Families of children and youth with special health care needs who require health care and community supports continue to identify barriers to receiving coordinated and comprehensive resources and supports for their child including medical, mental health, and dental care services. Although Wisconsin has a variety of services that enhance the opportunities that allow children with disabilities to stay in their homes and their families to become connected to the community, there remain many children who are receiving fragmented and inadequate health care services and community supports.

This priority focuses on promoting activities and policies to support infants, children, and adolescents with disabilities and special health care needs access to systems of care throughout their lifetime. By identifying and addressing challenges faced by families such as lack of understanding by professionals, lack of specialized providers and inadequate funding, the Wisconsin Maternal & Child Health Program expects efforts to promote comprehensive coordinated services and supports will result in social environments and public policies that lead to changes in:

NPM #02 Percent of children with special health care needs age 0 to 18 years whose families' partner in decision making at all levels and are satisfied with the services they receive.

NPM #05 Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily.

NPM #06 Percent of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

d) Increase the number of women, men, and families who have knowledge of and skills to promote optimal infant and child health, development, and growth

Optimum infant, child, and adolescent health, development and growth lays the foundation for health and success across the lifespan. This priority focuses on promoting activities and policies

that support healthy physical growth and development to ensure the birth of healthy infants and the nurturing and care of children and adolescents at home, early care and education, and health care settings.

By emphasizing the connection between early health status and development milestones with life-long health through a life course model, the Wisconsin Maternal & Child Health Program expects efforts to promote optimal infant, child, and adolescent health, growth and development will result in social environments and public policies that lead to changes in:

NPM #11 Percentage of mothers who breastfeed their infants at 6 months of age.

SPM #03 Percent of children age 10 months to 5 years who received a standardized screening for developmental or behavioral problems.

Outcome Measure: The infant mortality rate.

Outcome Measure: Neonatal mortality rate.

Outcome Measure: Post-neonatal mortality rate.

Outcome Measure: Perinatal mortality rate.

Outcome Measure: Child death rate.

Additional Measures: Proportion of parents reporting that a health provider assessed their child's learning, development, communication or social behavior.

e) Increase the number of women, children, and families who have optimal mental health and healthy relationships

Optimum mental health and healthy relationships provide the foundation for success across the lifespan and are essential to overall health. Helping children and adolescents develop healthy relationship skills early can contribute to their social-emotional development and help them interact positively with others as they grow. Children who grow up in healthy relationships respect others. They can talk honestly and freely to supportive people and share decisions. They trust and support each other and respect each other's independence. CYSHCN may need additional mental health supports.

This priority focuses on promoting activities and policies that support the development of healthy relationships and contribute to optimum mental health and social-emotional development. By emphasizing a public health approach to mental health, the Wisconsin Maternal & Child Health Program expects efforts to promote optimal mental health and healthy relationships will result in social environments and public policies that lead to changes in:

NPM #16 Rate per 100,000 of suicide deaths among youths aged 15 through 19.

SPM #04 Rate per 1,000 of substantiated reports of child maltreatment.

Additional Measures: Percent of children who have depression, anxiety or emotional problems; Percent of CSHCN and non-CSHCN who received mental health treatment in the past year; Incidence of intimate violence and hate crimes.

f) Increase the number of women, men, and families who have knowledge of and skills to promote optimal reproductive health and pregnancy planning

Because almost half of pregnancies in Wisconsin are not planned, many women are not aware they are pregnant until after the critical period of time (4-10 weeks after conception) has passed. As such, planning for the possibility of pregnancy or preconception care is recognized as a critical component of health care for women of reproductive age. The main goal of preconception care is to provide health promotion, screening and interventions for women of reproductive age to reduce

risk factors that might affect future pregnancies.

This priority focuses on promoting reproductive and sexual health. By encouraging adolescents to delay sexual activity, promoting access to reproductive health and family planning services for sexually active women of childbearing age and postpartum women, and promoting the adoption of healthy behaviors by women of childbearing age, the Wisconsin Maternal & Child Health Program expects efforts to promote optimal reproductive health and pregnancy planning will result in social environments and public policies that lead to changes in:

NPM #08 Rate of Birth (per 1,000) for teenagers aged 15 - 17 years of age.

NPM #15 Percent of moms who smoke in the last three months of pregnancy.

NPM #17 Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

NPM #18 Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

SPM #05 Percent of eligible women enrolled in the Wisconsin Medicaid Family Planning Waiver during the year.

SPM #06 Percent of women having a live birth who reported having an unintended or unwanted pregnancy.

Additional Measures: Percent of births that are to women with avoidable risks for poor birth outcomes; Percent of sexually active high school students who reported that they or their partner had used a condom during last sexual intercourse; Unintended pregnancy rates.

g) Increase the number of women, children, and families who receive preventive screenings, early identification, and intervention

Identification of health risks and concerns as early as possible in the lifespan, during developmentally sensitive periods yields the greatest benefits for optimal health. Many risk factors that can be identified and influenced in childhood and adolescence are directly connected to chronic diseases later in life.

This priority focuses on increasing access to preventive screening and treatment services for mothers, children, and families. By supporting and implementing interventions that target risks and concerns as early as possible, the Wisconsin Maternal & Child Health Program expects efforts to promote preventive screenings at an individual and community level will result in social environments and public policies that lead to changes in:

NPM #01 Percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

NPM #12 Percent of newborns who have been screened for hearing before hospital discharge.

SPM #07 Percent of children under 1 year of age enrolled in Wisconsin's Birth to 3 Program.

h) Increase the number of women, children, and families who live in a safe and healthy community

Communities exert considerable influence on the health of mothers, children, and families. The immediate surrounding of a person, where he or she lives, plays an important role in influencing

individual behaviors as well as contributing to the overall health of an individual.

This priority focuses on helping communities reduce injuries, prevent violence against children and promote healthy physical and built environments. By supporting and implementing interventions that support injury prevention, emphasize safety and improve the quality of the environment, the Wisconsin Maternal & Child Health Program expects efforts to promote safe and healthy communities will result in social environments and public policies that lead to changes in:

NPM #10 Rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

HSI3a. Death rate among children aged 14 years and younger due to unintentional injuries.

HSI4a. Rate of all nonfatal injuries among children aged 14 years and younger.

The Wisconsin Maternal & Child Health Program will engage in collaborative activities with DHS partners to impact the following National Performance Measurements not identified above in the 2011 - 2015 priorities:

NPM #07 Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B (Primary Partner: Immunization Program)

NPM #09 Percent of third grade children who have received protective sealants on at least one permanent molar tooth (Primary Partner: Oral Health Program)

NPM #13 Percent of children without health insurance (Primary Partner: Division of Access and Accountability)

NPM #14 Percent of children, ages 2-5 years, receiving WIC services that have a BMI at or above the 85th percentile (Primary Partner: Nutrition & Physical Activity Program)

The scope of the priorities for 2011-2015 is broad and can only be addressed through work undertaken in collaboration with a wide variety of internal and external partners. Statewide and local activities to address the priorities have been developed and will be implemented over the next five years. Many factors may influence the activities being implemented to address each priority. Although the activities may change over time, the priorities themselves will stay the same unless ongoing surveillance of the needs of mothers and children indicates changes are needed.

//2012/ As part of the 2012 application, the MCH Program reviewed the eight priorities identified in the 2010 process with internal and external stakeholders and with MCH leadership. The input received through this review, as well as the public input received and an analysis of indicator data affirmed the priorities were still valid and no changes were needed as they still accurately reflect the needs of Wisconsin's maternal and child population.

Because the priorities relate to the life course framework, the priorities continue to provide a strong foundation for the current services and activities of the MCH Program and its partners and will continue to support improved outcomes for the MCH population and strengthen our partnerships.

Impacts on State MCH Program and system partners due to the overall economic downturn, reduced state revenues in WI and reductions in federal block grant allocation as well as decreased employment in the recession and reduced access to health insurance and services since the previous NA will be closely monitored to determine impact on the MCH populations.

//2012//

*/2013/ The priorities identified in the 2010 needs assessment will continue to drive the MCH program in 2013. A review of key MCH indicators and stakeholder input again confirms that the priorities accurately reflect the needs of the MCH population in WI. //2013//*

## C. National Performance Measures

**Performance Measure 01:** *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	106	118	115	124	112
Denominator	106	118	115	124	112
Data Source		WI St Lab Hyg 2009.	WI St Lab Hyg 2010.	WI St Lab Hyg 2011.	WI Sta Lab Hyg 2012.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	100	100	100	100	100

#### Notes - 2011

Source: Numerator: NBS program, State Lab of Hygiene, Wisconsin, 2012. The number of infants that were confirmed with a condition through newborn screening and who receive appropriate follow-up care.

Denominator: NBS program, State Lab of Hygiene, Wisconsin, 2012. The number of infants screened through NBS and confirmed with a condition.

Wisconsin screens for 44 congenital disorders. Every newborn with an abnormal NBS result is tracked by the NBS Program to a normal result or appropriate clinical care.

#### Notes - 2010

Source: Numerator: NBS program, State Lab of Hygiene, Wisconsin, 2011. The number of infants that were confirmed with a condition through newborn screening and who receive appropriate follow-up care.

Denominator: NBS program, State Lab of Hygiene, Wisconsin, 2011. The number of infants screened through NBS and confirmed with a condition.

Wisconsin screens for 47 congenital disorders. Every newborn with an abnormal NBS result is tracked by the NBS Program to a normal result or appropriate clinical care.

#### Notes - 2009

Source: Numerator: NBS program, State Lab of Hygiene, Wisconsin, 2010. The number of infants that were confirmed with a condition through newborn screening and who receive appropriate

follow-up care.

Denominator: NBS program, State Lab of Hygiene, Wisconsin, 2010. The number of infants screened through NBS and confirmed with a condition.

Wisconsin screens for 47 congenital disorders. Every newborn with an abnormal NBS result is tracked by the NBS Program to a normal result or appropriate clinical care.

#### **a. Last Year's Accomplishments**

##### **1. Newborn Screening--Population-Based Services--Infants**

In 2011, 67,057 infants were screened for 47 different congenital disorders. 112 infants were confirmed with a condition screened for by the NBS Program and 100% were referred for appropriate follow-up care. The NBS Coordinator organized the biannual NBS Advisory Group--Umbrella Committee, and seven subcommittee meetings and an Ad-hoc NBS Task Force. The NBS Program, Wisconsin Sound Beginnings EHDI, Vital Records, and Birth Defects Surveillance System explored linking newborn screening data with other birth data. The blood card number was successfully added to the state vital records database and birth certificate data entry staff were trained on how to complete the field.

##### **2. Diagnostic Services--Direct Health Care Services--Infants**

The Department provided necessary diagnostic services, special dietary treatment as prescribed by a physician and follow-up counseling for the patient and his or her family through contracts with specialty clinics and local agencies. Five cystic fibrosis centers, three metabolic clinics, one sickle cell comprehensive care center, one genetics center, and a local health department receive these contracts. The DPH Newborn Screening Coordinator worked with the contracted agencies to promote and improve the NBS Program through the establishment and evaluation of performance-based objectives. These include the following focus areas: early identification, referral, ongoing clinical services, assessment, care coordination with the medical home, links to services, and transitions to adult care. Work with the contract agencies also included the coordination and tracking of nutritional products for congenital disorders patients.

##### **3. Development of Educational Materials--Enabling Services--Pregnant women and families with infants.**

Newsletters were sent to birth hospital coordinators with regular updates and reminders about newborn screening. A survey was sent to the hospital coordinators to gain feedback about NBS resources. A "plain clothes" NBS brochure was developed for the Amish and Mennonite population to assist in educating about NBS.

The Wisconsin NBS Program continued to participate in the HRSA "Region 4 Genetics Collaborative" grant with Wisconsin representatives in all workgroups. The regional collaborative allows states to share expertise in new technologies and best practice models to maximize available newborn screening resources.

**Table 4a, National Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. Newborn Screening			X	
2. Diagnostic Services	X			
3. Development of Educational Materials		X		
4.				
5.				
6.				
7.				

8.				
9.				
10.				

## **b. Current Activities**

### **1. Newborn Screening--Population-Based Services--Infants**

All WI infants are screened for 44 congenital disorders and for hearing loss. (Three metabolic conditions were removed from the NBS panel per Metabolic Advisory Subcommittee and Umbrella Committee.)

The NBS Program, Wisconsin Sound Beginnings EHDI, Vital Records, and Birth Defects Surveillance System continue to link newborn screening data with other birth data and are working to provide linkage reports which would allow follow up for babies born without NBS.

The Umbrella Advisory Group and 7 subcommittees meet. A proceedings paper document looking at the sustainability of the NBS program and the criteria for adding or deleting conditions as addressed at the Task Force meetings is in its final stages.

### **2. Diagnostic Services--Direct Health Care Services--Infants**

Objectives with agencies contracted to provide direct services relate to diagnosis; referral for services and clinical care; care coordination in a medical home; and transitions.

### **3. Development of Educational Materials--Enabling Services--Pregnant women and families with infants**

Education continues via newsletter, NBS Brochures, NBS DVD, Educational toolkit, websites and development of a new website

The NBS Program works with the Region IV Genetic Collaborative to share the web-based programming. The Guide for Families developed by the Medical Home Education Workgroup is shared with families and health care providers in coordination with the CYSHCN Medical Home hub.

## **c. Plan for the Coming Year**

### **1. Newborn Screening--Population-Based Services--Infants**

In 2013, all infants born in WI will continue to be screened at birth for a minimum of 44 congenital disorders and for hearing loss.

WI is one of six states that successfully applied for a grant to support Chronic Congenital Heart Disease (CCHD) screening activities. The grant period begins June 1, 2012 and funding continues for 3 years. The University of Wisconsin Pediatric Cardiology was the applicant; DHS will be an active partner. UW will be responsible for educational materials, screening protocols and follow-up for babies who fail the screening; DHS will be responsible for collecting data and providing data analysis services in years 2 and 3. The project will require DHS participation by the NBS program, Sound Beginnings EHDI, birth defects, and vital records.

The NBS Advisory Group (Umbrella Committee) and its Cystic Fibrosis/Molecular, Metabolic, Hemoglobinopathy, Endocrine, Immunodeficiency, Education and Hearing subcommittees will meet to advise the Department regarding emerging issues and technology in NBS. The NBS Task Force will finalize a proceedings paper document to highlight the outcome of the 3 meetings regarding the sustainability of the program and the addition or deletion of conditions process. An Ad Hoc Task Force will be established to address 22q11 microdeletion disorder.

## 2. Diagnostic Services--Direct Health Care Services--Infants

DHS will continue documenting in a computer-based tracking system for NBS dietary services. Tracked services will include the provision of dietary formulas and medical food products to children with conditions screened for by NBS by dieticians at contracted specialty centers. Performance based contracts will be reviewed and revised to continue to promote Medical Home implementation strategies such as care coordination and transition planning.

## 3. Development of Educational Materials--Enabling Services--Pregnant women and families with infants

The NBS Advisory Group Education Subcommittee will continue to educate the public and medical providers about congenital disorders; continue to improve communication with the NBS program and hospitals through e-newsletters and the development of a NBS website; continue to provide an educational tool kit for childbirth educators and health care providers with information about newborn screening and newborn screening resources; will use the NBS DVD as an education piece in a variety of settings to educate about Newborn Screening and will provide a "plain clothes" NBS brochure and education for the Amish and Mennonite populations.

The blood and hearing screening staff will continue to coordinate and integrate outreach and education to hospitals.

The NBS Program will work with the Region IV Genetics Collaborative to share developed resources like the Guide for Families with Wisconsin partners and continue to coordinate efforts and information regarding long-term follow up of NBS patients.

## Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

<b>Total Births by Occurrence:</b>	<b>67721</b>					
<b>Reporting Year:</b>	<b>2011</b>					
<b>Type of Screening Tests:</b>	<b>(A) Receiving at least one Screen (1)</b>		<b>(B) No. of Presumptive Positive Screens</b>	<b>(C) No. Confirmed Cases (2)</b>	<b>(D) Needing Treatment that Received Treatment (3)</b>	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	67057	99.0	8	4	4	100.0
Congenital Hypothyroidism (Classical)	67057	99.0	329	42	42	100.0
Galactosemia (Classical)	67057	99.0	0	0	0	
Sickle Cell Disease	67057	99.0	17	9	9	100.0
Biotinidase	67057	99.0	0	0	0	

Deficiency						
Cystic Fibrosis	67057	99.0	205	21	21	100.0
Fatty Acid Oxidation	67057	99.0	196	13	12	92.3
Organic Acidemia	67057	99.0	123	18	18	100.0
Aminoacidopathies	67057	99.0	54	1	1	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	67057	99.0	222	4	4	100.0
Severe Combined Immune Deficiency	17510	25.9	4	0	0	

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	70.5	71	71.5	72	72.5
Annual Indicator	65.3	65.3	74.4	74.4	74.4
Numerator	132074	132074	149937	149937	149937
Denominator	202257	202257	201529	201529	201529
Data Source		SLAITS CSHCN.	2009/10 NCHS CSHCN.	2009/10 NCHS CSHCNS.	2009/10 NCHS CSHCNS.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	75	75	80	80	80

#### Notes - 2011

Data issue: 2011 data are not available.

Data source: 2009-10 National Survey of Children with Special Health Care Needs, conducted by the CDC, National Center for Health Statistics, Wisconsin Profile. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

According to SLAITS documentation, numbers are not comparable for the data years 2005-06 and 2009-10.

#### Notes - 2010

Data source: 2009-10 National Survey of Children with Special Health Care Needs, conducted by the CDC, National Center for Health Statistics, Wisconsin Profile. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. According to SLAITS documentation, numbers are not comparable for the data years 2005-06 and 2009-10.

#### **Notes - 2009**

Data source: 2009-10 National Survey of Children with Special Health Care Needs, conducted by the CDC, National Center for Health Statistics, Wisconsin Profile. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. According to SLAITS documentation, numbers are not comparable for the data years 2005-06 and 2009-10.

#### **a. Last Year's Accomplishments**

##### **1. Family Support Services--Enabling Services--CYSHCN**

In 2011, Parent to Parent (P2P) of WI matched 128 families and provided support trainings in partnership with Alianza (Spanish parent org.), 2 parent support trainings and 37 parent matches. 122 families received education through Family Voices of WI (FVW); and 2,477 families received individual information and assistance through the Regional Centers and subcontracted agencies enhancing parents as decision makers and supporting informal networks of support.

##### **2. Coordination with Family Leadership and Support--Population-Based Services--CYSHCN**

In 2011, the CYSHCN Program contracted with FVW to provide: an electronic or hard copy newsletter to 2,500 individuals; health policy updates disseminated through the listserv and posted on the FV website; TA to the Regional Centers; 67 notices for parent leadership and public policy opportunities; and 13 health benefits trainings reaching 37 providers and 1,232 families. Additional outreach went to Spanish newspapers and radio stations.

##### **3. Participation of Families on Advisory Committees to the MCH and CYSHCN Program--Infrastructure Building Services--CYSHCN**

Parents continue to serve in advisory capacities i.e., FVW listening session at Circles of Life Conference, MCH Advisory Committee. The Regional Centers, FVW, and Parent to Parent all serve on a broad range of local, state, and national councils and committees where parents continue to participate in various system leadership activities.

In 2008 the CYSHCN Program was awarded a MCHB-Combating Autism Act Initiative State Implementation grant, developing a Community of Practice on ASD and DD which continued to meet through October 2011, with a parent of a child with ASD serving as Co-Chair. Participants included parents of children with ASD and DD, FVW, Parent to Parent of WI, Regional Centers, several youths and adults with ASD, professionals, providers, UW, Waisman Center, DPI, CESAs, and several parent-led ASD organizations i.e., ASW, ASSEW, ASGM, ASNEW, ARC, and Easter Seals.

##### **4. Family Partnerships--Infrastructure Building Services--CYSHCN**

Parents of CYSHCN continue as staff of the State CYSHCN Program, all 5 Regional Centers, Parent to Parent (P2P), and FVW, making parents integral to decision-making, program implementation and evaluation. CYSHCN partners continue to meet as a Collaborators Network.

#### **Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Support Services		X		
2. Coordination with Family Leadership and Support			X	
3. Participation of Families on Advisory Committees to the MCH and CYSHCN Program				X
4. Family Partnerships				X
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

##### **1. Family Support Services--Enabling Services--CYSHCN**

Families receive parent matching, training, care coordination, and information, & assistance.

##### **2. Coordination with Family Leadership and Support--Population-Based Services--CYSHCN**

The CYSHCN Program contracts with 5 CYSHCN Regional Centers, 4 hubs of expertise, and P2P. The CYSHCN Program contracts with FVW for the Family Leadership Hub to provide: a newsletter; listserv; policy updates; and health benefits training for under-represented populations including Tribal parents.

##### **3. Participation of Families on Advisory Committees to the MCH and CYSHCN Program--Infrastructure Building Services--CYSHCN**

Parents continue their advisory roles serving on: The CoP ASD and DD, Newborn Screening Program, WI Sound Beginnings, Birth Defects Prevention and Surveillance Program, Children' Long Term Supports Council, and the MCH Advisory Committee.

##### **4. Family Partnerships--Infrastructure Building Services--CYSHCN**

Parents continue as staff at all levels of the CYSHCN Program. The CYSHCN Collaborators Network shares best practices and plan ways to improve existing collaborations. FVW tracks unmet needs and collaborates with disability Advocacy organizations helping to bring the needs of families to legislators and state agency leaders. Wisconsin's family delegate to AMCHP Family and Youth Leadership Committee in 2012 continues. Preliminary work is done to involve more families in AMCHP.

#### **c. Plan for the Coming Year**

##### **1. Family Support Services--Enabling Services--CYSHCN**

In 2013, families will continue to be matched through Parent to Parent of WI program, receive education through FVW, care coordination through ABC for Health, and offered I&R through the Regional Centers. Families will continue to be members of the MCH Advisory committee, and the Community of Practice on ASD and DD as new regional leadership sustains the initiative, and the Community of Practice on Transition. All these groups support family and youth in leadership roles and include practice groups on parent supports and roles for youth.

##### **2. Coordination with Family Leadership and Support--Population-Based Services--CYSHCN**

In 2013, the CYSHCN Program will continue to contract for the services provided by FVW with those of the Family to Family Health Information Network grant through MCHB. FVW will continue to build a parent network and provide: a newsletter, health benefits training targeting under-represented populations; data collection, analysis and dissemination of unmet needs; and assistance in Regional Center transition to adult health care trainings.

Outreach to underserved populations will continue to target Latino, African American, and Native American families, including families with children who are deaf or hard of hearing ie. WI Families for Hands and Voices. The WSB Program in collaboration with WIC program sites, informs families of infants who did not pass the hearing screening of the need for follow-up and resources. 12 WIC projects coordinate hearing screening follow-up with scheduled WIC clinic visits.

Parent to Parent will continue to work with the SE Regional Center and Alianza to reach Spanish speaking families with training on Parent to Parent supports and efforts to identify non-English speaking match parents.

### 3. Participation of Families on Advisory Committees to the MCH and CYSHCN Program--Infrastructure Building Services--CYSHCN

Parents will continue their advisory capacities through the Regional Centers, and be linked to opportunities to serve at a local, regional, or state level. The staff at the Regional Centers, Parent to Parent and other partner and collaborating agencies will continue to serve on a range of councils and committees to advance the performance measure on parents as decision makers.

### 4. Family Partnerships--Infrastructure Building Services--CYSHCN

In 2013 parents will continue to be part of the staffing at all levels of the CYSHCN Program. The CYSHCN Collaborators Network will meet annually and quarterly by phone, building the CYSHCN system and assuring parents as partners are coordinated across programs. The Information and Referral group will continue so that staff can inform families regarding the ever-changing health benefits system. FVW will continue to track unmet needs in collaboration with CYSHCN partners so that family needs are articulated on a policy level.

**Performance Measure 03:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	61	55	57	58	59
Annual Indicator	54.6	54.6	44.1	44.1	44.1
Numerator	110432	110432	88874	88874	88874
Denominator	202257	202257	201529	201529	201529
Data Source		SLAITS CSHCN.	2009/10 NCHS CSHCN.	2009/10 NCHS CSHCNS.	2009/10 NCHS CSHCNS.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-					

year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	45	45	50	50	50

#### **Notes - 2011**

Data issue: 2011 data are not available.

Data source: 2009-10 National Survey of Children with Special Health Care Needs, conducted by the CDC, National Center for Health Statistics, Wisconsin Profile. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### **Notes - 2010**

Data source: 2009-10 National Survey of Children with Special Health Care Needs, conducted by the CDC, National Center for Health Statistics, Wisconsin Profile.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### **Notes - 2009**

Data source: 2009-10 National Survey of Children with Special Health Care Needs, conducted by the CDC, National Center for Health Statistics, Wisconsin Profile.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### **a. Last Year's Accomplishments**

##### **1. Medical Home Education and Training--Population-Based Services--CYSHCN**

Beginning in 2011 the CYSHCN Program supported the Wisconsin Statewide Medical Home Initiative (WISMHI) at the NE Regional Center to serve as the Medical Home "hub" and lead for CYSHCN related medical home activities. Staff includes a consultant pediatrician, family physician and parent. The Medical Home Toolkit (<http://wimedicalhometoolkit.aap.org/toolkit/index.cfm>) and Medical Home webcast series ([www.waisman.wisc.edu/connections/webcast.php](http://www.waisman.wisc.edu/connections/webcast.php)) were disseminated at presentations for primary practice offices and at a variety of meetings with different stakeholder groups. WISMHI also promoted best practice, evidence-based developmental and ASD screening within context of a medical home in partnership with Regional Centers and Birth-3. 75 primary care providers were trained in the ASQ 3 and M-CHAT. WISMHI also partnered with Project Launch in Milwaukee outreaching to inner city pediatric providers on developmental screening and behavioral health and facilitated a meeting with Oregon Project Start. Follow up from the meeting includes drafting a common referral form to Birth-3 and establishment of a policy workgroup to look at reimbursement issues specific to developmental screening.

##### **2. Medical Home Outreach--Population-Based Services--CYSHCN**

Dissemination of Medical Home concepts continued to be integrated in Wisconsin Sound Beginnings (WSB), Early Hearing Detection and Intervention (EHDI), and Congenital Disorders (blood spot newborn screenings) Programs. Practices were asked by WISMHI to report on the availability of newborn hearing screening results at the time of the first baby visit. Results were used to target outreach to providers and hospitals to improve the communication of hearing

screening results. The WI EHDI QI toolkit has information specific to the Medical Home ([www.improveehdi.org/wi/medicalhome/bestpractices.cfm](http://www.improveehdi.org/wi/medicalhome/bestpractices.cfm)).

### 3. Medical Home and Community Supports--Infrastructure Building Services--CYSHCN

WISMHI meets quarterly with the WI Chapter AAP (WIAAP) and Wisconsin Academy of Family Practice (WAFP). CYSHCN Regional Centers continued to develop relationships with providers to assist with community connections, and I and R. Regional Centers engaged in 99 MH infrastructure activities. A Medical Home Practice Group continued in conjunction with Community of Practice on ASD and DD. The WISC-U database at the Waisman Center provided a mechanism to record provider/practice level Medical Home implementation.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medical Home Initiative				X
2. Medical Home Outreach			X	
3. Medical Home and Community Supports, Education, and Training			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

##### 1. Medical Home Initiative--Infrastructure Building Services--CYSHCN

The CYSHCN Program continues to fund WISMHI. FVW, Regional Centers and other CYSHCN Collaborator Network agencies integrate MH concepts into their trainings. WISMHI contracts with P2P to support MH training for families. Standardized training materials are being developed for use by parent partners. The WISC-U database at the Waisman Center records provider/practice level Medical Home implementation to assure coordination among CYSHCN partners. WISMHI coordinates with ECCS, Project LAUNCH & the SAMSHA supported Healthy Transitions grant and meets regularly with WIAAP, WAFP, and the State MCH Program.

##### 2. Medical Home Outreach--Population-Based Services--CYSHCN

WISMHI promotes screening as part of MH implementation and coordination with programs such as WSB, the Congenital Disorders Program, Birth Defects, and MCH Program. WISMHI also partners with the Learn the Signs Act Early Ambassador and WI surveillance project (WISADDMS) at the UW-Waisman Center to promote WI specific materials ([www.actearly.wisc.edu/](http://www.actearly.wisc.edu/)) among primary care providers and families.

##### 3. Medical Home and Community Supports, Education, and Training--Population-Based Services--CYSHCN

WISMHI will host the CoP on ASD/DD focusing on care coordination and mental health. In partnership with the Transition Hub at the UW/American Family Children's Hospital, WISMHI plans a Medical Home and Transition Summit for November with input from WAFP, WIAAP leadership.

### c. Plan for the Coming Year

#### 1. Medical Home Initiative--Infrastructure Building Services--CYSHCN

CYSHCN Program continues contracting with WISMHI as the statewide lead for CYSHCN Medical Home activities. The CYSHCN Program will continue to work with WAFP, WI AAP, and MCH ECS to promote the concept of medical home for CYSHCN and foster its growth and spread in communities across the state. Staff will maintain connections to a variety of medical home activities around the state to continue to keep the needs of CYSHCN and systems as a focus, and will work to influence stakeholder groups as Wisconsin continues to move toward patient-centered medical home/health home implementation maintaining our presence and influence regarding MCH/CYSHCN and medical home.

The State CYSHCN Program and its contracted agencies will continue to promote Medical Home spread and offer technical assistance supports through work with key partners on the local, regional and state levels. Regional Centers will reach out to new providers in their regions to assist with community connections, information and referrals in coordination with WISMHI. The database of practices engaged in Medical Home activities will be utilized to coordinate Medical Home outreach and education and quality improvement activities among hubs and Centers.

#### 2. Medical Home Outreach--Population-Based Services--CYSHCN

WISMHI will continue to coordinate with programs such as WSB, ECCS, Project LAUNCH, the Congenital Disorders Program, Birth Defects and MCH ECS. WISMHI will continue to partner with the UW-Waisman Center LEND to promote Learn the Signs Act Early WI specific materials ([www.actearly.wisc.edu/](http://www.actearly.wisc.edu/)) among families, health care providers, childcare, Head Start and Birth-3 (Part C).

#### 3. Medical Home and Community Supports, Education and Training--Population-Based Services--CYSHCN

WISMHI will continue its outreach to families in partnership with FVW, P2P, and Regional Centers to promote the concepts of MH. Tools such as the "Partnering with your Doctor" developed by the Region 4 Genetics Collaborative and WI CYSHCN Program's Tips for Families will continue to be utilized. WISMHI will continue to coordinate with WI Project LAUNCH per LAUNCH Strategic plan. WISMHI and the CYSHCN Regional Centers will identify and implement strategies to support local health departments participating in the WI Healthiest Families Initiative of the MCH Early Childhood Systems (ECS) work.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	69.5	64	65	66	67
Annual Indicator	63.0	63.0	65.1	65.1	65.1
Numerator	127442	127442	131195	131195	131195
Denominator	202257	202257	201529	201529	201529
Data Source		SLAITS CSHCN.	2009/10 NCHS CSHCNS.	2009/10 NCHS CSHCNS.	2009/10 NCHS CSHCNS.

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	68	68	70	70	70

#### **Notes - 2011**

Data issue: 2011 data are not available.

Data source: 2009-10 National Survey of Children with Special Health Care Needs, conducted by the CDC, National Center for Health Statistics, Wisconsin Profile.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### **Notes - 2010**

Data source: 2009-10 National Survey of Children with Special Health Care Needs, conducted by the CDC, National Center for Health Statistics, Wisconsin Profile.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### **Notes - 2009**

Data source: 2009-10 National Survey of Children with Special Health Care Needs, conducted by the CDC, National Center for Health Statistics, Wisconsin Profile.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### **a. Last Year's Accomplishments**

##### **1. Health Benefits Services--Enabling Services--CYSHCN**

The CYSHCN Regional Centers and FVW partnered in every region of the state with 13 "Did You Know You Know" health insurance supports training for 159 families of whom 37 were providers and 22 were family members.

##### **2. Access to Health Insurance--Infrastructure Building Services--CYSHCN**

The Regional Centers continued assisting families to secure health insurance including access to SSI and Medicaid coverage through information, referral and follow-up. 555 CYSHCN records had insurance information reported in SPHERE. 245 had Medicaid coverage, 152 had BadgerCare, 259 had private insurance, and 13 had other health insurance coverage.

##### **3. Access to Dental Care Services--Infrastructure Building Services--CYSHCN**

The Wisconsin Oral Health Program continued to provide TA, contracting with CHAW to administer a HRSA grant to promote oral health as a part of total health care for CYSHCN and to organize community resources to increase access to dental care for CYSHCN. Program

objectives were carried out by oral health coordinators in each public health region. Activities included training 186 dental professionals, providing oral health education, dental services and case management for CYSHCN and their families in Head Start, and schools statewide. The Regional Oral Health Consultants (ROHC) conducted oral health trainings for 439 health care providers, residential care providers and community organizations. School-based services included collaboration with the WI Seal-A-Smile dental sealant program to ensure inclusion of CYSHCN. During the 2010-2011 school year, 3,633 CYSHCN were provided dental services in the Seal-A-Smile program.

#### 4. Health Insurance Coverage for young adults up to age 26--Enabling Services--CYSHCN

Health plans are required to allow parents to keep their children under age 26 without job-based coverage on their family's coverage. As of June 2011, 27,511 young adults in Wisconsin gained insurance coverage as a result of the new health care law.

#### 5. Removing the Cap on Family Care--Direct Health Care Services--CYSHCN

WI Act 127, removes the cap on Family Care and similar programs that provide community-based long-term care, and it allows expansion of Family Care into 15 counties.

#### 6. Administration of Medication to Pupils--Direct Health Care Services--CYSHCN

WI Act 86 eliminates the requirement that a nurse who distributes medication to pupils have a bachelor's degree from an approved nursing program.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Health Benefits Services		X		
2. Access to Dental Care Services				X
3. Children's Long Term Support Medicaid Waivers	X			
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

##### 1. Health Benefits Services--Enabling Services--CYSHCN

The CYSHCN Program continues the 5 Regional Centers, 4 hubs of expertise and P2P.

##### 2. Access to Dental Care Services--Infrastructure Building Services--CYSHCN

Oral health activities for CYSHCN continue since the conclusion of the HRSA grant in 2011 with services integrated into agencies employing ROHC. CHAW and the WI Oral Health Program provide oral health education, training and prevention services to CYSHCN in the Seal-A-Smile program, community and school programs. TA of student and practicing dental providers in professional education programs, FQHCs and other safety net dental clinics continue.

##### 3. Children's Long Term Support Medicaid Waivers--Direct Health Care Services--CYSHCN

The Bureau of Long Term Support reported 402 children are on wait-lists for intensive services - 814 are receiving intensive In-Home Autism services (559 DD; 255 SED). 1,597 children transitioned to ongoing Autism services (1,275 DD; 2 PD; 320 SED). There are a total of 5022 children receiving direct services with the following eligibility: developmental disabilities, 3,505; physical disabilities, 380; and severe emotional disturbances 1,137. There are: 1,111 children receiving services through locally matched waivers (660 DD; 111 PD; 340 SED); 25 children in pilot slots (15 DD; 7 PD; 3 SED); 64 children in Crisis - State Match slots (DD 40, 7, PD, 17 SED) and 1,475 children in state matched slots (956 DD; 253 PD; 202 SED).

### **c. Plan for the Coming Year**

#### **1. Health Benefits Services--Enabling Services--CYSHCN**

ABC for Health will continue as the CYSHCN Statewide Access/Health Benefits Counseling hub of expertise, providing direct technical support in the form of trainings consultation and care coordination.

#### **2. Access to Health Insurance--Infrastructure Building--CYSHCN**

The Regional Centers will continue assisting families to secure health insurance through I & R and follow-up, health benefits counseling as appropriate, and provide training and technical assistance to the CYSHCN Collaborators Network partners on health access and coverage issues. They will begin to integrate activities with the MCH ECS Initiatives statewide providing training and TA to support community level collaborations addressing children and youth with special health care needs.

Through the Nourishing Special Needs WIC/CYSHCN Network, we will continue to problem-solve access to Medicaid nutritional services for CYSHCN.

#### **3. Access to Dental Care Services--Infrastructure Building Services--CYSHCN**

CHAW and the WI Oral Health Program are committed to oral health for CYSHCN and will continue to provide TA and guidance to increase the knowledge and skills of dental health providers on a targeted basis. Future plans include activities in collaboration with the Seal-A-Smile program and other school-based oral health programs, WI Regional Centers for CYSHCN, Autism Connections, CYSHCN Collaborator's Network and other state agencies working with CYSHCN and their families.

#### **4. Access to Mental Health Services for CYSHCN--Infrastructure Building Services--CYSHCN**

The following goals continue through the Children's Mental Health Committee: 1) Expand collaborative systems of care (i.e., wraparound), with a goal of children's wraparound systems in each of Wisconsin's 72 counties within 6 years; 2) Create financial incentives to increase family advocacy and support for counties with a Coordinated Services Team (CST) initiative; 3) Increase mental health early intervention activities; 4) Increase children's mental health training and consultation for teachers and preschool/daycare providers; 5) Take steps to increase the availability of qualified mental health providers throughout Wisconsin.

#### **5. Children's Long Term Support Waiver--Direct Health Care Services--CYSHCN**

Access to Autism Waiver Services will change in Spring 2012 with revisions to intensive autism treatment within the Children's Long Term Support waiver with expanding to Tiers 1 & 2 categories; with changes in Hours, Allowable Costs, Service Location, Family Involvement, and Allowable Number of Years in Program.

#### **6. BadgerCare--Direct Health Care Services--CYSHCN**

BadgerCare child participants with disabilities will mostly be unaffected by the cost cutting changes approved by the Federal HHS. However, it will become more complicated in the application process and in maintaining coverage as different policies will apply for children and parents regarding eligibility and premiums.

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	84.5	91	91	92	92
Annual Indicator	90.0	90.0	64.6	64.6	64.6
Numerator	182031	182031	130187	130187	130187
Denominator	202257	202257	201529	201529	201529
Data Source		SLAITS CSHCN.	SLAITS CSHCN.	2009/12 NCHS CSHCNS.	2009/12 NCHS CSHCNS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	65	65	70	70	70

**Notes - 2011**

Data issue: 2011 data are not available.

Data source: 2009-10 National Survey of Children with Special Health Care Needs, conducted by the CDC, National Center for Health Statistics, Wisconsin Profile.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

According to SLAITS documentation, numbers are not comparable for the data years 2005-06 and 2009-10.

**Notes - 2010**

Data source: 2009-10 National Survey of Children with Special Health Care Needs, conducted by the CDC, National Center for Health Statistics, Wisconsin Profile.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

According to SLAITS documentation, numbers are not comparable for the data years 2005-06 and 2009-10.

**Notes - 2009**

Data source: 2009-10 National Survey of Children with Special Health Care Needs, conducted by the CDC, National Center for Health Statistics, Wisconsin Profile.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

According to SLAITS documentation, numbers are not comparable for the data years 2005-06 and 2009-10.

#### **a. Last Year's Accomplishments**

##### **1. Access to Individual/Household Services--Enabling Services--CYSHCN**

Individuals, families, and providers who contact the 5 CYSHCN Regional Centers and their subcontracted agencies received direct assistance, referrals to other professionals, or other interventions by Center and local staff. In 2011, according to data entered in SPHERE, there were 5,555 CYSHCN-funded contacts and services provided, with 2,477 individual/household interventions and 3,078 brief contacts. Brief contacts include consultations that are face-to-face, on the telephone, or in writing.

##### **2. Community Based Services--Population-Based Services--CYSHCN**

Partnerships at the local, regional and state levels were advanced through co-sponsored events and cross-referral plans and collaborative efforts were established to serve identified target populations. The CYSHCN Program and its Regional Centers have delineated key committees and conferences where CYSHCN representation is critical and an outreach plan specifies responsibilities over the state.

##### **3. Planning and Implementing Community Based Projects--Infrastructure Building Services--CYSHCN**

CYSHCN staff implemented year one of the five-year cycle based on outcomes from the 2010 MCH needs assessment. Four statewide hubs of expertise (Family Leadership, Health Benefits/Access, Medical Home and Youth Health Transition), P2P and 5 Regional Centers for CYSHCN completed their first year in the grant cycle. An overall coordination element is required to assure that all of these CYSHCN-funded entities work in close collaboration through regular Directors meetings, the CYSHCN Collaborators Network Intranet and monthly information and referral teleconferences.

The established CYSHCN Collaborators Network and the CYSHCN Program continue to work collaboratively with many partners to assure that CYSHCN are identified early, receive coordinated care, and that their families have access to the supports they need. These collaborative partnerships include: P2P; Family Voices of WI; Great Lakes Inter-Tribal Council (GLITC); ABC for Health and ABC for Rural Health; First Step; Wisconsin Chapters of the AAP and WAFP; Early Intervention ICC; Wisconsin Early Childhood Collaborating Partners; MCH ECS, Department of Public Instruction's Wisconsin Statewide Parent-Educator Initiative; the Parent Training and Information Center-WI FACETS; statewide Wisconsin Asthma Coalition; WI Infant Mental Health Assoc; and the Circles of Life Conference Planning Committee. ALIANZA LATINA APLICANDO SOLUCIONES, Latino Alliance Applying Solutions, is a partner that has become more involved in the network and especially in reaching Latino families. The annual Collaborators meeting focused on understanding the Life Course model and its relevance to CYSHCN NPMs. The WIC CYSHCN Nutritionists attended strengthening the partnership.

The Wisconsin-specific navigation guide (English and Spanish) was completed and disseminated to regional and local partners to assist families in understanding how to find services and supports. This resource was made available online. Region-specific Autism Spectrum Disorders (ASD) resource sheets were produced in collaboration with the CAAI ASD State Implementation grant.

The Nourishing Special Needs network expanded to 18 WIC nutritionists who work with the Regional Centers to improve nutritional services for CYSHCN. A mentorship was started in 2010 in which 9 CYSHCN trained WIC nutritionists were matched with 9 new WIC nutritionists. The 16 project sites made 48% of the WIC referrals to the Wisconsin Birth to Three Program and 78% of the WIC referrals to CYSHCN Regional Centers in 2011. Teleconference trainings are open to all 72 WI WIC sites including the CYSHCN Regional Centers creating a Birth Defects/CYSHCN Nutrition Consultant statewide network.

WI's MCH Targeted Oral Health Service Systems Grant entitled "WI Community-based System of Oral Health for CYSHCN," ended in 2011. It was a four-year grant administered through CHAW and facilitated partnership development between oral health and our Collaborators Network. This grant conducted oral health trainings for providers and CYSHCN around the state. The Director of this grant and the Statewide CYSHCN Coordinator presented at a webinar in October for The National Center for Ease of Use of Community-Based Services to highlight the partnership between oral health and state Title V CYSHCN programs.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Access to Individual/Household Services		X		
2. Community Based and System Based Services			X	
3. Planning and Implementing Community Based Projects				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

**1. Access to Individual/Household Services--Enabling Services--CYSHCN**

In 2012, the 5 Regional Centers and their delegate agencies continued to provide information and assistance to families and providers. LHDs continue to have the option of providing these services at a local level. Families are linked to trainings and parent support opportunities to address their needs.

**2. Community Based and System Based Services--Population-Based Services--CYSHCN**

A Wisconsin-specific navigation guide continues to be disseminated to assist families in understanding how to find services and supports. Region-specific Autism Spectrum Disorders (ASD) resource guides, produced in collaboration with the CAAI ASD State Implementation grant, are also being disseminated.

**3. Planning and Implementing Community Based Projects--Infrastructure Building Services--CYSHCN**

The Regional Centers collaborate with their WIC-nutrition regional consultants who also are working with their LHDs. In 2012, the Waisman Center assumed coordination for the nutrition network with the LEND Director, a nutritionist, as lead.

The Oral Health Program Manager from the MCHB grant that ended in 2011, now leads a WI

Partnership grant to build on the previous CYSHCN-oral health to target early childhood populations.

Regional Centers continue to respond to local requests for training, outreach and assistance. The Collaborators Network continues to share resources, problem-solve, and cross-refer.

### **c. Plan for the Coming Year**

#### **1. Access to Case Management, Consultation and Referral and Follow-up Services--Direct Health Care Services--CYSHCN**

In 2013, the 5 CYSHCN Regional Centers will continue to provide information and assistance to families and providers. Families will be linked to trainings and parent support opportunities to meet their needs. It is expected that the Western Region will continue to subcontract with their LHDs for information and assistance.

#### **2. Community Based and System Based Services--Population-Based Services--CYSHCN**

The Regional Centers will partner with the CYSHCN hubs of expertise through the following: attend trainings and introduce the Center as a resource; assist with provider recruitment; provide community-related resource information to practice sites within their region; coordinate these and other Medical Home activities with partners; and assist with practice site follow up.

#### **3. Planning and Implementing Community Based Projects--Infrastructure Building Services--CYSHCN**

In partnership with other funding sources, the CYSHCN Program will plan and implement the following projects in 2013: continue to implement the CYSHCN Regional Centers and hubs of expertise model, strengthen the Collaborators Network's role to meet, share resources, problem-solve, cross-refer and identify unmet needs. The Network will continue to expand to include the Statewide Genetics Program and its partners. New efforts to strengthen the coordination of Title V/CYSHCN and Chronic Disease programs in the BCHP will work to integrate the needs of people with disabilities into all bureau programs across the life span. The Coordinated Chronic Disease Core Management Team Plus meets monthly and includes section chiefs and select program staff. Plans are underway to include the CYSHCN Program Medical Director in this team. This infrastructure change will promote more cross-section coordination and opportunities to address health and disability into existing bureau work.

The CYSHCN Program will continue to work to increase our program's visibility, focus more attention on early identification and screening and broaden the stakeholder group that meets regularly. We will continue to market our program and our collaborators as a network through common marketing themes and the use of common design elements in our materials, which will continue to be available on the CYSHCN Intranet.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

#### **Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	7	50	52	54	55
Annual Indicator	44.5	44.5	44.4	44.4	44.4

Numerator	90004	90004	89478	89478	89478
Denominator	202257	202257	201529	201529	201529
Data Source		SLAITS CSHCN.	2009/2010 SLAITS CSHCN.	2009/10 NCHS CSHCNS.	2009/10 NCHS CSHCNS.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	46	40	50	50	50

#### Notes - 2011

Data issue: 2011 data are not available. The objective for 2011 was based on previous data NCHS data from 2005-06 which were entered in the previous applications. We cannot change the objectives that were entered in previous years. We cannot change the objective for 2011. We have new data for 2009-2010 which we have entered for 2009 -2011. Our new objectives are based on these new and recent data.

Data source: 2009-10 National Survey of Children with Special Health Care Needs, conducted by the CDC, National Center for Health Statistics, Wisconsin Profile.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### Notes - 2010

Data source: 2009-10 National Survey of Children with Special Health Care Needs, conducted by the CDC, National Center for Health Statistics, Wisconsin Profile.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### Notes - 2009

Data source: 2009-10 National Survey of Children with Special Health Care Needs, conducted by the CDC, National Center for Health Statistics, Wisconsin Profile.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### a. Last Year's Accomplishments

##### 1. State Partnership Building--Infrastructure Building Services--CYSHCN

The statewide CYSHCN Youth Health Transition Hub was established at the American Family Children's Hospital (AFCH), part of the University of Wisconsin Health System. They conducted an environmental scan to assess current practices for the transition from pediatric to adult health care for YSHCN. Phone interviews were conducted with representatives from four institutions that care for children: Gundersen Lutheran (La Crosse), Children's Hospital of Wisconsin (CHW) (Milwaukee), Children's Hospital-Fox Valley (Neenah), and AFCH (Madison). One site visit was

conducted (Gundersen Lutheran). An internal scan to assess current efforts at UW Health was also conducted. There was great variability reported among respondents including differences in educational materials (content, distribution and target audience), staffing, staff training, existence of a policy, patient progress documentation, and data collection. Outcomes from this work included plans to convene a joint meeting between AFCH and CHW and plans for a web-based toolkit. A steering team met monthly and included the CYSHCN Medical Director, Transition hub staff and leadership from the Southern Regional Center. The CYSHCN Program supported the Community of Practice on Transition (CoT), a collaborative with representatives from over 40 state and community transition-related partners. CYSHCN staff served on the core leadership team and was a lead in the restructuring process that occurred in 2011. The Practice Group on Health sponsored three sessions on health and transition at the annual Wisconsin Transition Conference.

## 2. Outreach and Training--Outreach [Population-Based Services] and Training [Infrastructure Building Services]--CYSHCN

In October 2011, the hub was a broadcast site for Baylor University's 12th Annual Chronic Illness and Disability Conference: Transition from Pediatric to Adult-based Care. There were 25 participants representing the UW Health system, Waisman Center, Title V Program, Family Voices, and community members. The Transition to Adult Health Care curriculum, pocket guide, and workbook were reprinted and disseminated to prepare YSHCN and their families for the move from pediatrics to adult health care. The CYSHCN My Health Pocket Guide was requested from a LPHD in Colorado and they translated it into Spanish and have used the English and Spanish copies as part of trainings across their state.

## 3. Access to Transition Information--Enabling Services--CYSHCN youth

The CYSHCN Program disseminated quality information to families and providers using web-based, hard copy, oral and face-to-face approaches. Through the CoP, the Regional Centers have developed key partnerships and extensive knowledge of the Wisconsin and national resources on transition which has enhanced the Centers ability to answer the parents question, problem solve solutions and/or refer families to the appropriate entity. Booklets on health-related transition topics were reprinted and disseminated at conferences, the CoP on Transition, youth and parent trainings. The Regional Centers provide ongoing transition information and assistance.

## 4. Access to Transition Services--Infrastructure Building--Youth with Serious Mental Health Conditions

In 2009, the DMHSAS received a 5-year SAMHSA Healthy Transitions Initiative grant to create developmentally-appropriate and effective services that will improve outcomes for youth and young adults with serious mental health conditions. The CYSHCN Program met with the state leaders for this grant and took a lead on putting together a WI team in preparation for a 2012 Learning Community: Young Adults with Behavioral Health Concerns: Improving Access to a Health/Medical Home in Annapolis.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. State Partnership Building				X
2. Outreach and Training—Outreach [Population-Based Services] and Training [Infrastructure Building Services]			X	X
3. Access to Transition Services				X
4.				
5.				

6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

##### **1. State Partnership Building--Infrastructure Building Services--CYSHCN**

The CYSHCN Program, Youth Health Transition hub and CHW facilitated a meeting to bring leadership from AFCH and CHW together to share transition best practice models, challenges and strategies within their institutions. Follow-up action steps & plans for another collaborative check-in are planned for the fall. A transition fact sheet is being developed. The Medical Home and Transition hubs will co-sponsor a Youth Transition into Adult Health Care Summit in the Fall of 2012. The CYSHCN Program continues to share leadership for the Community of Practice on Transition and Regional Centers provide transition information and assistance.

##### **2. Outreach and Training--Outreach [Population-Based Services] and Training [Infrastructure Building Services]--CYSHCN**

A 3rd printing of My Health Pocket Guide and the web-based toolkit will be completed. There were 3 health and transition sessions at the annual statewide transition conference. Materials were disseminated at statewide conferences: Transition Conference, Circles of Life Conferences for professionals and parents, and through the Family to Family Health Information Center. Family Voices uses these transition materials to conduct regional trainings.

##### **3. Access to Transition Services--Infrastructure Building--Youth with Serious Mental Health Conditions**

The CYSHCN Medical Director led a WI team to a national Learning Community: Young Adults with Behavioral Health Concerns.

#### **c. Plan for the Coming Year**

##### **1. State Partnership Building--Infrastructure Building Services--CYSHCN**

In 2013, the Youth Health Transition hub of expertise will further establish itself as a source of evidence-based practice resources, information, outreach and training. The CYSHCN Collaborators Network comprised of Wisconsin CYSHCN-funded entities including the 5 Regional Centers, Family to Family Health Information Center, FVW, P2P, will all be involved in disseminating transition information and resources to families, youth and providers. AFCH will take a leadership role in the CoP on Transition, its facilitator team and the Practice Group on Health and work closely with the Collaborators Network. AFCH will utilize the hub of expertise to keep current and disseminate state and national information to WI stakeholders. This model follows the national MCH model of having one training and technical assistance center for each NPM. The CYSHCN Medical Director and staff will continue to collaborate with the SAMSHA Healthy Transitions Initiative grant state leaders to coordinate Title V and mental health initiatives.

##### **2. Outreach and Training--Outreach [Population-Based Services] and Training [Infrastructure Building Services]--CYSHCN**

The web-based toolkit will be updated by the Transition hub and will serve to be a central repository of youth health transition resources, best practice models and linkages to training. The hub will collaborate with all five Regional Centers, be integrated into the CYSHCN Collaborators Network, and provide training and technical assistance to youth, parents, health care providers, community providers and educators. The work will include the continued use and dissemination

of the five transition materials that the CYSHCN Program developed in 2009 and reprinted in 2011/2012 including the following: Transition to Adult Health Care: A Training Guide, My Pocket Guide, The Health Care Checklist, The Youth Workbook, Health and the IEP CD ([www.waisman.wisc.edu/wrc/pub.html](http://www.waisman.wisc.edu/wrc/pub.html)). These materials and content will be disseminated at the two primary transition-related state conferences (Transition and Circles of Life). Family Voices will continue to conduct regional transition trainings, in collaboration with the Regional Centers.

### 3. Access to Transition Information--Enabling Services--CYSHCN

The CYSHCN Program will disseminate quality information to families and providers using web-based, hard copy, oral and face-to-face approaches. Regional Centers, the Youth Health Transition hub and state staff will continue to support the CoT. The 5 Regional Centers will continue to provide information, referral, and follow-up services to families requesting transition information.

**Performance Measure 07:** *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	83.4	83.5	83.6	83.7	83.7
Annual Indicator	79.3	79.3	83.6	83.6	86.5
Numerator	349	349	368	368	237
Denominator	440	440	440	440	274
Data Source		CDC Nat Imm Surv 2009.	CDC Nat Imm Surv 2010.	CDC Nat Imm Surv 2009.	CDC Nat Imm Surv 2010-2011.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	87	87	87.5	87.5	88

#### Notes - 2011

Source: CDC National Immunization Survey, June 2010 - 2011. Coverage for the 43133 series with any 3+ Hib is 86.6% (SE 2.4).

#### Notes - 2010

The source of these data is the National Immunization Survey of a random sample of Wisconsin children who were born between January 2005 and June 2007. We have used the NIS consistently as our source to monitor this indicator. The Wisconsin Immunization Registry is a statewide registry for tracking immunizations for adults and children, however its use is not yet statewide by all providers, therefore, it does not provide a representative sample needed to track and report this measure over time. It is however, for now, a very useful tool for individual clinical practice and immunization administration for those who use it regularly.

## Notes - 2009

The source of these data is the National Immunization Survey of a random sample of Wisconsin children who were born between January 2005 and June 2007.

### a. Last Year's Accomplishments

1. Providing, Monitoring and Assuring Immunizations--Direct Health Care Services--Children, including CYSHCN

Title V staff supported LHDs primary prevention activities including immunization monitoring and support compliance with State Immunization Program funding requirements.

2. Coordination with WIC and the State Immunization Programs and Enrollment in the WI Immunization Registry (WIR)--Infrastructure Building Services--Pregnant women, mothers, infants and children, including CYSHCN.

State partnerships continued with Title V MCH/CYSHCN Program, LHDs, WIC Program, Medicaid Program, Tribes and Community Health Centers (CHCs).

3. Tracking and Sharing Policy Changes or Clinical Practices by the State Immunization Program--Infrastructure Building Services--Pregnant women, mothers, infants and children, including CYSHCN

National and international circumstances that result in recommended changes in the immunization schedule continued to be tracked by the State Immunization Program in 2011 with policy sharing occurring as appropriate.

4. Quality Improvement of Vaccines for Children Program--Infrastructure Building Services--Children, including CYSHCN

During 2011 at provider site visits, quality improvement efforts were promoted and supported by staff in the State Immunization Program.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing, Monitoring and Assuring Immunizations	X			
2. Coordination with WIC and the State Immunization Programs and Enrollment in the WI Immunization Registry (WIR)				X
3. Tracking and Sharing Policy Changes or Clinical Practices by the State Immunization Program				X
4. Quality Improvement of Vaccines for Children Program				X
5.				
6.				
7.				
8.				
9.				
10.				

### b. Current Activities

1. Providing, Monitoring and Assuring Immunizations--Direct Health Care Services--Children, including CYSHCN

In 2012, WI achieved an 84% immunization coverage rate among children aged 19-35 mo. DPH

received the 2012 national award for Highest Childhood Immunization Coverage from CDC. WI immunization rates were measured by the National Immunization Survey (NIS for the time period of Q1/2010-Q2/2011, and included specific series of vaccines (DTaP, polio, MMR, Hep B, varicella, Pneumococcal and Hib; Hib vaccine data was excluded this year because of a vaccine shortage).

2. Coordination with WIC and the State Immunization Programs and Enrollment in the WI Immunization Registry (WIR)--Infrastructure Building Services--Pregnant women, mothers, infants and children, including CYSHCN.

State Immunization Program partnered with Title V Program, LHDs, WIC Program, Medicaid Program, Tribes, and CHCs.

3. Tracking and Sharing Policy Changes or Clinical Practices by the State Immunization Program--Infrastructure Building Services--Pregnant women, mothers, infants and children, including CYSHCN

National and international circumstances that result in recommended changes in the immunization schedule continue to be tracked with policy sharing occurring as appropriate.

4. Quality Improvement of Vaccines for Children Program--Infrastructure Building Services--Children, including CYSHCN

QI efforts for providers will be maintained through site visits by Immunization Program staff.

### **c. Plan for the Coming Year**

1. Providing, Monitoring and Assuring Immunizations--Direct Health Care Services--Children, including CYSHCN

Title V MCH Program staff will continue to support LHDs primary prevention activities including immunization monitoring and support compliance with the State Immunization Program funding requirements.

2. Coordination with WIC and the State Immunization Programs and Enrollment in the WI Immunization Registry (WIR)--Infrastructure Building Services--Pregnant women, mothers, infants and children, including CYSHCN.

State Immunization Program will continue to partner with Title V MCH/CYSHCN Program, LHDs, WIC Program, Medicaid Program, Tribes, and CHCs in 2013.

3. Tracking and Sharing Policy Changes or Clinical Practices by the State Immunization Program--Infrastructure Building Services--Pregnant women, mothers, infants and children, including CYSHCN

During 2013, national and international circumstances, resulting in policy and recommended changes in the immunization schedule will be tracked and shared by the State Immunization Program.

4. Quality Improvement of Vaccines for Children Program--Infrastructure Building Services--Children, including CYSHCN

Provider site visits will be done throughout 2013 by State Immunization Program staff promoting and supporting quality improvement efforts.

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	14.7	14.9	16.1	16.1	13.9
Annual Indicator	16.0	15.4	13.9	11.7	11.7
Numerator	1874	1783	1608	1345	1345
Denominator	117042	115440	115796	114825	114825
Data Source		WI DHS/OHI 2009.	WI DHS/OHI 2010.	WI DHS/OHI 2012.	WI DHS/OHI 2012
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	11	10.9	10.8	10.7	10.6

**Notes - 2011**

Data issue: Data will not be available for 2011 from the Office of Health Informatics until 2013.

**Notes - 2010**

Data notes: There were 57 births to teens <15 years in 2010. Sources: Numerator: Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics. Births to Teens in Wisconsin, 2010, P-45365-10), January 2012. Denominator: Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH) data query system, <http://dhs.wisconsin.gov/wish>. Population Module, accessed 04/25/12.

**Notes - 2009**

Data notes: There were 61 births to teens <15 years in 2010. Sources: Numerator: Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Births and Infant Deaths, 2009 (P-45364-09). May 2011. Denominator: Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH) data query system, <http://dhs.wisconsin.gov/wish>. Population Module, accessed 04/25/11.

**a. Last Year's Accomplishments**

1. Milwaukee Adolescent Pregnancy Prevention Partnership (MAPPP) & Personal Responsibility Education Program (PREP) Grant--Enabling Services--Adolescents

In 2011, the MAPPP initiative was combined with the new PREP Grant Initiative to maximize these joint efforts to reduce the teen birth rate and STI rate and drop-out rate for at-risk youth ages 10 to 19 years of age in the cities of Milwaukee, Racine, and Beloit where these rates were the highest. An RFP was developed and issued, and 6 grantees in WI received grants for \$100,000 to implement the PREP Programming. The grantees included Center for Self

Sufficiency, Neighborhood House, Silver Spring Neighborhood Center, and AIDS Resource Center of Wisconsin, all from Milwaukee; the YMCA in Racine and Community Action Inc. in Beloit. Each grantee is required to reach 150 youth per year with all components of the program.

Core PREP programming is centered around the evidence based pregnancy and STI prevention curricula Making Proud Choices and Street Smart. United Way of Milwaukee has been retained to train the trainers for Making Proud Choices and conduct the follow up fidelity monitoring. Connected Health Solutions out of New York has provided Train the Trainer sessions for Street Smart and Planned Parenthood of Wisconsin has been retained to monitor the Fidelity of Street Smart. Three adult preparation subjects must also be included in programming and for WI, those selected include: Healthy Relationships, Financial Literacy, and Educational Attainment/Career Exposure. All 6 grantees are working together to implement the Financial Literacy using a Money Conference model. Asset Builders of America out of Madison has been retained to provide the Financial Literacy training and technical assistance to grantees. The Money Conference model takes place over a 6 hour day, and involves 4-6 workshops that every youth attending rotates through. There are key note speakers, youth enticing incentives raffled off, music and DJ's and youth performances to create a youth friendly atmosphere.

In addition to the prevention programming for youth, stakeholder groups have been established in each of the 3 communities. The stakeholders groups are made up of professionals from each community who are interested in the issue and concerned about the teen pregnancy and STI rates in their community. Stakeholders groups will help raise awareness in their respective communities about the issue of teen pregnancy and STI contraction, and will look at community wide solutions including accessing reproductive health care through the use of the Family Planning Only Medicaid benefit.

## 2. DPH Unintended Pregnancy and STD Prevention Initiative (DPPI)--Population-Based Services--Adolescents

The DPPI initiative continued its collaboration with City of Milwaukee Health Department's STD clinic by being a major source of referrals for the MAPPP clinic partner agencies. The City of Milwaukee Health Department was also added as contract agency for the PREP Grant Initiative in the area of Youth Plain Talk.

## 3. Teen Pregnancy Prevention Coalition Efforts--Population-Based Services--Adolescents

DPH continued its partnership with the Milwaukee (ASHCOM) Coalition Partners and Leaders in teen pregnancy prevention. In 2011, the focus was on a better integration with the Milwaukee Teen Pregnancy Prevention Oversight Committee and the state's overall efforts.

## 4. State Health Plan--Infrastructure Building Services--Adolescents

In 2011, a major focus of the state efforts centered on how to move forward with the implementation of Healthiest Wisconsin 2020 State Health Plan and specifically what should be the metrics we use to determine the progress for the reproductive/sexual health priority areas.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Milwaukee Adolescent Pregnancy Prevention Partnership (MAPPP) & Personal Responsibility Education Program (PREP) Grant		X		
2. DPH Unintended Pregnancy and STD Prevention Initiative (DPPI)			X	
3. State Health Plan				X

4.				
5.				
6.				
7.				
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9.				
10.				

#### **b. Current Activities**

##### **1. Milwaukee Adolescent Pregnancy Prevention Partnership (MAPPP) & Personal Responsibility Education Program (PREP) Grant--Enabling Services--Adolescents**

The MAPPP/PREP Initiatives successfully kicked off its joint implementation in 2012 with all 6 sites securing contracts, hiring staff, receiving training on selected evidenced-based curricula and holding direct sessions with youth. The PREP Initiative is halfway through its first year and the outreach goal of 900 youth being served is on target. To date, there have been 3 money conferences reaching 339 youth.

The MAPPP Initiative-like expansion in Racine and Beloit is under development.

##### **2. DPH Unintended Pregnancy and STD Prevention Initiative (DPPI)--Population-Based Services--Adolescents**

The MAPPP/PREP Initiatives continue to utilize the DPPI Initiative to help drive referrals to clinic partner agencies. Efforts to streamline and simplify the referral process is being made. The addition of the PREP Initiative provides a wider array of other Milwaukee geographic locations with which to draw clients.

##### **3. State Health Plan--Infrastructure Building Services--Adolescents**

In 2012, a major focus of DHS state efforts have centered on the internal Health Disparities Task Force that will feature a new data presentation format.

#### **c. Plan for the Coming Year**

##### **1. Milwaukee Adolescent Pregnancy Prevention Partnership (MAPPP) & Personal Responsibility Education Program (PREP) Grant--Enabling Services--Adolescents**

DPH will continue implementation of PREP programming with 900 youth per year exposed to evidenced-based curricula (Making PROUD Choices & Street Smart) and adult preparation topics of financial literacy, healthy relationships & educational attainment. Additionally, contractual agreements will be established with collaboratives in the cities of Racine & Beloit to expand the MAPPP Initiative.

##### **2. DPH Unintended Pregnancy and STD Prevention Initiative (DPPI)--Population-Based Services--Adolescents**

This initiative continues to be a priority standard of practice and strategy for the MAPPP & PREP agency grantees. Dual protection interventions will be aggressively promoted through standardized messages and services/supplies to all MAPPP & PREP agency sites. Collaborations will increase across all MAPPP & PREP sites and the MHD's STD clinic and community-based clinics to provide BC0FPOS enrollment, immediate care, and actively manages referrals for a health care home for continuing preventive care in the community.

##### **3. Teen Pregnancy Prevention Coalition Efforts--Population-Based Services--Adolescents**

The state teen pregnancy prevention leadership will re-establish regular meetings with the

Milwaukee ASHCOM Leadership Group. This includes continued coordination with the Milwaukee Teen Pregnancy Prevention Oversight Committee.

#### 4. State Health Plan--Infrastructure Building Services--Adolescents

Progress toward the Healthiest Wisconsin 2020 reproductive/sexual health objectives and measures will be made and access to and promotion of evidenced-based information (informed decisions) and services will remain a priority.

#### **Performance Measure 09:** *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

##### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	50	50	51	51	52
Annual Indicator	47.0	50.8	50.8	50.8	50.8
Numerator	34134	35806	35806	35806	35806
Denominator	72626	70484	70484	70484	70484
Data Source		WI DHS/DPH 2009.	WI DHS/DPH 2009.	WI DHS/DPH 2009.	WI DHS/DPH 2009.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	52	53	54	55	56

##### **Notes - 2011**

Data issue: Numerator and denominator are weighted estimates from the Wisconsin Division of Public Health "Make Your Smile Count, The Oral Health of Wisconsin's Children" survey of third grade children, 2007-08. The unweighted data are: 2,212 and 4,353. If funding is available, the Oral Health Program is scheduled to do the next survey during the 2012-13 school year.

##### **Notes - 2010**

Data issue: Numerator and denominator are weighted estimates from the Wisconsin Division of Public Health "Make Your Smile Count, The Oral Health of Wisconsin's Children" survey of third grade children, 2007-08. The unweighted data are: 2,212 and 4,353.

##### **Notes - 2009**

Data issue: Numerator and denominator are weighted estimates from the Wisconsin Division of Public Health "Make Your Smile Count, The Oral Health of Wisconsin's Children" survey of third grade children, 2007-08. The unweighted data are: 2,212 and 4,353.

#### **a. Last Year's Accomplishments**

1. Wisconsin Seal-A-Smile Sealant Program--Direct Health Care Services--Children

The Wisconsin Seal-A-Smile (SAS) statewide school-based dental sealant program provided funding to 41 programs. Due in large part to a HRSA grant award of \$325,000/yr for three years with private sector matching funds of \$241,000 for the same three years, the Program has experienced significant growth. This robust expansion pattern is expected to continue. In the 2010/11 school year, SAS programs screened 29,518 children, placed 74,276 dental sealants on 17,767 children, and provided fluoride treatments to 23,499 children. Dental sealants and fluoride varnish are recognized as evidence-based primary prevention interventions to reduce the prevalence and incidence of dental decay. The SAS program average cost to seal each child was about \$110. The Oral Health Program (OHP) contracts with CHAW to administer and monitor the SAS program. Through a CDC Cooperative Agreement, the OHP continued to have a dedicated Dental Sealant Coordinator. The Coordinator works in collaboration with the Alliance to administer and monitor the SAS program. In addition, the Coordinator provides technical assistance in program development to LHDs, agencies and individuals interested in establishing a SAS program in their communities. SAS program development and expansion is dedicated to areas of WI with the highest need. SAS criteria for funding requires that programs provide services in schools where the free and reduced price meal program eligibility is 35% or greater. It is the intent of the WI SAS program to provide programming in all schools across the state meeting this criteria. Special attention is being focused on those schools with a free and reduced meal program eligibility of 50% and higher. In the 2010/11 school year, SAS programs provided services in 406 schools, of those schools 229 had free and reduced meal program eligibility of 50% or higher.

## 2. Wisconsin Oral Health Program Infrastructure Support--Infrastructure Building Services--Children including CYSHCN

In 2008, the WI OHP was the recipient of a CDC Cooperative Agreement award. The award is designed to increase capacity and build infrastructure to assure Wisconsin has an adequate oral health workforce to successfully address statewide needs. The award allowed for the creation of a Dental Sealant Coordinator to enhance and expand the program. The OHP has a highly trained Dental Sealant Coordinator and is positioned to meet the growing needs of our state.

## 3. Technical Assistance--Enabling Services--Children, including CYSHCN

Technical assistance was provided to the 41 statewide grantees in collaboration with CHAW's Oral Health Program Manager. The OHP Dental Sealant Coordinator provides ongoing project specific technical assistance and outreach to potential expansion grantees. The MCH funded State Chief Dental Officer and the MCH funded State Public Health Dental Hygienist assist in monitoring grantee contracts, review of grantee proposals and provide technical support as needed.

## 4. Oral Health Surveillance--Population Based Services--Children, including CYSHCN

In the 2007-2008 school year, the Wisconsin Division of Public Health OHP conducted its second "Make Your Smile Count Survey" oral health assessment of third grade students. The total sample of children evaluated was 4,355. The survey data revealed that 50.8% of Wisconsin third grade students had evidence of dental sealants on at least one permanent tooth, exceeding the Healthy People 2010 objective for sealants. It is the intention of the OHP to continue to exceed national objectives related to dental sealants, monitor progress and evaluate program.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Wisconsin Seal-A-Smile Sealant Program	X			
2. Wisconsin Oral Health Infrastructure Support				X
3. Technical Assistance		X		

4.				
5.				
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#### **b. Current Activities**

##### **1. WI Seal-A-Smile Sealant Program--Direct Health Care Services--Children, including CYSHCN**

The OHP anticipates continued funding to the current school-based dental sealant programs, as well as the creation of new programs along with expansion of current programs. There will no longer be funding available from the HRSA grant; however, additional funding has been allocated from State General Purpose Revenue (GPR) to the SAS Program. Matching funding will continue from the private sector. The OHP will continue to actively engage LHDs, agencies and individuals to establish and or expand programs. The OHP will again be working with CHAW on the established goals and objectives and will be specifically targeting opportunities to reach CYSHCN through the school based dental sealant program. The OHP will continue to require all SAS funded programs to collect data on CYSHCN based on the vetted questionnaire obtained by the DHS CYSHCN Program.

##### **2. Wisconsin Oral Health Infrastructure Support--Infrastructure Building Services--Children, including CYSHCN**

The Program will continue to contract with CHAW.

##### **3. Technical Assistance--Enabling Services--Children, including CYSHCN**

Technical assistance is currently being provided to 41 statewide grantees.

##### **4. Oral Health Surveillance--Population Based Services--Children, including CYSHCN**

Data on CYSHCN will continue to be collected and those children identified with additional needs will be case managed to assure services are provided

#### **c. Plan for the Coming Year**

##### **1. Wisconsin Seal-A-Smile Sealant Program--Direct Health Care Services--Children**

The OHP anticipates continued funding to the current school-based dental sealant programs, as well as the creation of new programs along with expansion of current programs. There will no longer be funding available from the HRSA grant, however, additional funding has been allocated from State GPR to the SAS Program. Matching funding will continue from the private sector. The OHP will continue to actively engage LHDs, agencies and individuals to establish and or expand programs. The OHP will again be working with CHAW on the established goals and objectives and will be specifically targeting opportunities to reach CYSHCN through the school based dental sealant program. The OHP will continue to require all SAS funded programs to collect data on CYSHCN based on the vetted questionnaire obtained by the DHS CYSHCN Program.

##### **2. Wisconsin Oral Health Infrastructure Support--Infrastructure Building Services--Children including CYSHCN**

The Program will continue to contract with Children's Health Alliance to administer the SAS program and provide training and guidance to new staff/programs. The OHP will work closely with the CYSHCN program regarding the collection of data on dental sealant program participants

who report as CYSHCN.

### 3. Technical Assistance--Enabling Services--Children, including CYSHCN

Technical assistance will be provided to the statewide project grantees in cooperation with CHAW. The MCH funded State Chief Dental Officer and Public Health Dental Hygienist will continue to play an active role in the Wisconsin Oral Health Coalition (WOHC). Through the CDC Cooperative Agreement, the OHP is able to fund a dedicated Coalition Coordinator. The Coalition Coordinator will devote the time necessary to develop the WOHC by engaging diverse partners and directing outcomes, to enhance the awareness of oral health disparities for our CYSHCN. The OHP will continue to work with the CHAW on the goals and objectives of the SAS Program and will continue to target school based opportunities to reach CYSHCN.

### 4. Oral Health Surveillance--Population-Based Services--Children, including CYSHCN

In conjunction with the WI Oral Health Coalition (WOHC), the 2007-2008 Make Your Smile Count third grade oral health assessment will be used to provide a framework for ongoing program and policy development and community advocacy. A statewide WOHC meeting will be held to engage additional partners and will be used as an avenue to promote the successes of the SAS program. These meetings have a strong LHD attendance. This will allow for OHP staff to meet individually with LHDs and gauge their interest in developing new or expanded dental sealant programs.

**Performance Measure 10:** *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	2.8	2.8	2.5	2.5	2.5
Annual Indicator	2.5	2.0	1.7	1.5	1.5
Numerator	27	22	18	16	16
Denominator	1086602	1086686	1084021	1102987	1102987
Data Source		WI DHS/OHI 2010.	WI DHS/OHI 2011.	WI DHS/OHI 2012.	WI DHS/OHI 2011.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	1.4	1.4	1.4	1.4	1.4

#### Notes - 2011

Data issue: Data for 2011 will not be available from the Office of Health Informatics until 2013; therefore, the indicator for 2010 (1.5) and 2010 (1.5) are the data that we used for subsequent years' objectives.

### Notes - 2010

Source: Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH), <http://dhfs.wisconsin.gov/wish/>, Injury Mortality Module, accessed 03/05/2012.

Although in 2010, Wisconsin's rate of death for children <14 years caused by motor vehicle was less than in previous years, we do not necessarily see a trend because the number of children who die per year in motor vehicle crashes is relatively small, and the rate may be adversely affected by only a slight increase or decrease in the number of events. Therefore, we have set our objectives to the best of our ability.

### Notes - 2009

Source: Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH), <http://dhfs.wisconsin.gov/wish/>, Injury Mortality Module, accessed 04/08/2011.

#### a. Last Year's Accomplishments

##### 1. Car Seat Safety Education and Fitting/Inspections--Enabling Services--Infants and children

In 2011, 31 LHDs conducted checks for proper installation and use of car seat restraints through MCH contracts. We are continuing to evaluate this objective to assure that it meets the needs of both LHDs and the MCH Program.

##### 2. Community Education and Outreach--Population-Based Services--Infants and children

Education to support the proper use of child passenger safety seats continued in 2011. We strongly encourage partnership with local organizations, such as SAFE KIDS, hospitals, fire departments and local business to support this activity within their communities. We continued our technical assistance to LHDs.

##### 3. Enhancement and Expansion of Partnerships--Infrastructure Building Services--Infants and children

LHDs continue to utilize partnerships with DOT, law enforcement agencies, local hospitals, EMS, and SAFE KIDS to support their efforts to provide education and services pertaining to child passenger safety. Money is also available from DOT for staff training and education and for purchasing car seats for low income families.

##### 4. Community Systems Development--Infrastructure Building--Infants and Children

In 2011, the MCH Program implemented the Keeping Kids Alive (KKA) and the WI Healthiest Families Initiative (WHFI) with 51 LHDs in the state. KKA focuses on Child Death Review and Fetal Infant Mortality Review to be implemented by local or regional teams in a systematic manner. Case review findings will lead to recommendations for prevention. WHFI includes a focus on safety and injury prevention. LHDs will work with community partners to plan, implement and evaluate prevention strategies based on recommendations of the mortality review teams. Training and TA for LHDs will be provided by CHAW for KKA and by the UW Cooperative Extension for WHFI.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Community Systems Development				X
2.				
3.				

4.				
5.				
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10.				

#### **b. Current Activities**

##### **1. Community Systems Development--Infrastructure Building--Infants and Children**

In 2012, the MCH Program expanded the Keeping Kids Alive (KKA) and the WI Healthiest Families Initiative (WHFI) to all LHDs in the state. Training and TA for LHDs will continue to be provided by CHAW for KKA and by the UW Cooperative Extension (UW Extension) for WHFI. Many local health departments are utilizing the WHFI initiative to assess their communities current child passenger safety education and fitting stations looking towards a more systematic and sustainable approach to these efforts. Additional expectations include working within community institutions to identify organization policies that may enhance motor vehicle safety for children (i.e., hospital policy requiring a CPS technician to check all seats before a new baby is discharged). Further, via the new KKA Initiative, additional data will be available to track outcomes and engage new partners. It is expected that MCH staff will again work on the Strategic Highway Safety Plan. Enabling services continue within these initiatives.

#### **c. Plan for the Coming Year**

##### **1. Community Systems Development--Infrastructure Building--Infants and Children**

The MCH Program will continue to support local early childhood systems building with options to focus on safety and injury prevention and/or Keeping Kids Alive, among other areas. Both of these areas have the potential to reduce child deaths from motor vehicle crashes. The emphasis is on community driven priorities and utilization of the life course framework. The MCH Program will continue to provide technical assistance in these areas to local communities along with their statewide partners the CHAW and the UW Extension.

**Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

#### **Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	25	26	28	29	28
Annual Indicator	26.6	27.1	27.5	26.4	26.4
Numerator	3622	3784	3901	3621	3439
Denominator	13616	13963	14185	13715	13025
Data Source		CDC PedNSS 2009.	CDC PedNSS 2010.	CDC PedNSS 2010.	CDC PedNSS 2011.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than					

5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	28	29	29	29	30

#### **Notes - 2011**

Source: 2011 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention. CDC is discontinuing the PedNSS. We will use the National Immunization Survey for subsequent years.

#### **Notes - 2010**

Source: 2010 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention.

#### **Notes - 2009**

Source: 2009 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention.

#### **a. Last Year's Accomplishments**

1. Breastfeeding Education, Promotion, and Support--Enabling Services--Pregnant and breastfeeding women

In April 2011 the Building Breastfeeding Competencies for WIC training was provided to 58 staff.

2. Breastfeeding Peer Counseling and Breast Pump Distribution--Enabling Services--Pregnant and breastfeeding women

In CY 2011, the WIC Program trained 14 new breastfeeding peer counselors who provided prenatal breastfeeding counseling and postpartum support in 56 local WIC projects statewide. The WIC Breastfeeding Incidence and Duration Report indicated improved breastfeeding rates with the BF Peer Counselor Program initiation and 6 month duration rates at 72.9% and 26.9% compared to the State average of 69.9% and 25.1%. More than 4,200 breast pumps were distributed by the WIC Program in 2011. In March 2012, 15 new WIC breastfeeding peer counselors were trained. Ongoing quarterly continuing education conference calls are provided for breastfeeding peer counselors and BFPCP Coordinators.

3. Wisconsin Breastfeeding Coalition--Population-Based Services--Pregnant and breastfeeding women

In June 2011, The Wisconsin Breastfeeding Coalition (WBC) held its first WBC Summit in Milwaukee with funding from the Wisconsin Partnership for Activity & Nutrition. In September 2011, the Building Bridges training was provided in Racine and Milwaukee hospitals to inform, influence, and impact breastfeeding friendly practices in hospitals. Over 140 medical providers including nurses, physicians, WIC staff, dietitians, student workers, and interns attended the trainings.

4. Collaboration and Partnerships: Breastfeeding Coalitions--Infrastructure Building--Pregnant and breastfeeding women

In March 2011, the Certified Lactation Specialist certification course was provided to 70 WIC and LHD staff through a WIC administrative grant.

In April 2011, the "Business Case for Breastfeeding" training was provided to 36 attendees including local breastfeeding coalitions, hospital, WIC, and LHD staff.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Breastfeeding Education, Promotion, and Support		X		
2. Breastfeeding Peer Counseling and Breast Pump Distribution		X		
3. Wisconsin Breastfeeding Coalition			X	
4. Collaboration and Partnerships: Breastfeeding Coalitions				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

1. Breastfeeding Education, Promotion, and Support--Enabling Services--Pregnant and breastfeeding

The Building Breastfeeding Competencies for WIC training is being planned for the fall of 2012 for all new staff and staff unable to attend the 2011 training. The WIC Breastfeeding Support online training module continues to provide breastfeeding orientation and education for all staff.

2. Breastfeeding Peer Counseling and Breast Pump Distribution--Enabling Services--Pregnant and breastfeeding women

March 2012, the WIC Program trained 15 new breastfeeding peer counselors who provide prenatal breastfeeding counseling and postpartum support in 62 local WIC projects statewide.

Ongoing quarterly continuing education conference calls are provided for breastfeeding peer counselors and BFPCP Coordinators.

3. Wisconsin Breastfeeding Coalition--Population-Based Services--Pregnant and breastfeeding women

April 2012, the Building Bridges training was provided in Green Bay and Fond du Lac hospitals to inform, influence, and impact breastfeeding friendly practices in hospitals. Over 160 medical providers including nurses, physicians, WIC staff, dietitians, student workers, and interns attended the trainings. June 2012, WBC holds the 2nd annual Breastfeeding Summit

4. Collaboration and Partnerships: Breastfeeding Coalitions--Infrastructure Building--Pregnant and breastfeeding women

The number of local breastfeeding coalitions increased from 26 in January 2011 to 30 in April 2012.

**c. Plan for the Coming Year**

1. Breastfeeding Education, Promotion, and Support--Enabling Services--Pregnant and breastfeeding

The Certified Lactation Specialist course and Building Breastfeeding Competencies for WIC training will be provided in 2013 as funding permits. The WIC Breastfeeding Support online training module will continue to provide breastfeeding orientation and education for all staff.

2. Breastfeeding Peer Counseling and Breast Pump Distribution--Enabling Services--Pregnant and breastfeeding women

The CY 2013 goal will be to continue to expand the BFPCP to all counties in the state and institutionalize peer counseling in WIC as a core service focused on increasing breastfeeding rates among WIC participants.

3. Wisconsin Breastfeeding Coalition--Population-Based Services--Pregnant and breastfeeding women

The WIC Breastfeeding Coordinator will continue to Chair the Breastfeeding Committee of the Wisconsin Partnership for Activity & Nutrition (WI PAN), serve on the executive committee of the Wisconsin Breastfeeding Coalition, and the WI PAN Coalition Support Team committee. The WBC will continue to provide materials, organizational tools, and strategies for breastfeeding promotion to local breastfeeding coalitions, hospitals, health departments, and other key stakeholders and increase the coordination of breastfeeding interventions and the number of evidence based strategies that are implemented statewide.

4. Collaboration and Partnerships: Breastfeeding Coalitions--Infrastructure Building--Pregnant and breastfeeding women

The WBC will continue to provide local breastfeeding coalitions ongoing technical assistance, consultation and training on designing evidence based strategies as defined by the CDC Guide to Breastfeeding Interventions and work to increase the number of local breastfeeding coalitions in Wisconsin.

**Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	95	97.5	97.5	96	96.5
Annual Indicator	97.2	96.5	95.7	96.4	98.9
Numerator	69364	68382	66688	64509	66108
Denominator	71389	70862	69654	66948	66823
Data Source		WI WETRAC 2009.	WI WETRAC 2010.	WI WETRAC 2010.	WI WETRAC 2011.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	99	99	99	99	99

**Notes - 2011**

Data issue: If infants die or refuse a hearing screening, that is noted on the blood card. Therefore, the denominator in NPM 12 was adjusted to remove cases of refusal and expiration. Wisconsin Sound Beginnings, the State of Wisconsin's Early Hearing Detection and Intervention (EHDI) program maintains an electronic database called the Wisconsin EHDI Tracking, Referral and Coordination (WE-TRAC) system.

Hearing screening results are reported on the Wisconsin State Lab of Hygiene (WSLH) blood screening card. Birth hospitals perform a heel stick and a hearing test, record the results, and send the card to the WSLH. Data are entered from the blood screening card into the WSLH database. Hearing specific information is then messaged from the WSLH database to WE-TRAC. Processing logic and business rules dictate how records are handled. Records with PASS/PASS results are archived and records with a REFER (did not pass) or MISSING results are placed on a birth hospital or out of hospital provider queue for follow-up.

In May 2010, Wisconsin Act 279 was enacted. The bill requires the physician, nurse-midwife or certified professional midwife who attended the birth to ensure that the infant is screened and that parents are advised of the results. This passage of the legislation was especially important, because Wisconsin has a high out-of-hospital birth population. The EHDI program has a longstanding working relationship with Wisconsin Guild of Midwives. The organization has a number of screeners that are shared between practices. Most screenings typically occur at the 1 week visit, which are not counted in the prior to hospital discharge data.

#### **Notes - 2010**

Data issue: \*If infants expire or refuse a hearing screening, it can be denoted on the blood card. For this reason, the denominator in NPM 12 has been adjusted to remove cases of refusal (227 cases) and expiration (104).

Wisconsin Sound Beginnings, the State of Wisconsin's early hearing detection and intervention (EHDI) program maintains an electronic database called the Wisconsin EHDI Tracking, Referral and Coordination (WE-TRAC) system.

Hearing screening results are reported on the Wisconsin State Lab of Hygiene (WSLH) blood screening card. Birth hospitals perform a heel stick and a hearing test, record the results, and send the card to the WSLH. Data is entered from the blood screening card into the WSLH database. Hearing specific information is then messaged from the WSLH database to WE-TRAC. Processing logic and business rules dictate how records are handled. Records with PASS/PASS results are archived and records with a REFER (did not pass) or MISSING results are placed on a birth hospital or out of hospital provider queue for follow-up.

In May 2010, Wisconsin Act 279 was enacted. The bill requires the physician, nurse-midwife or certified professional midwife who attended the birth to ensure that the infant is screened and that parents are advised of the results. This passage of the legislation was especially important, because Wisconsin has a high out of hospital birth population. The EHDI program has a longstanding working relationship with Wisconsin Guild of Midwives. The organization has a number of screeners that are shared between practices. Most screenings typically occur at the 1 week visit, which aren't counted in the prior to hospital discharge data. In 2010, 64,862 (96.9% of occurrent births) passed their screening by 1 month of age.

#### **Notes - 2009**

Hearing screening results are reported on the Wisconsin State Lab of Hygiene (WSLH) newborn blood screening card. Data are entered into the WSLH database and messaged to the Wisconsin Early Hearing Detection and Intervention Tracking Referral and Coordination (WE-TRAC) system. Processing logic within WE-TRAC filters incoming records and hearing screening results.

Records with PASS/PASS results are archived and records for infants with REFER or missing results are placed on a birth hospital queue for follow-up. Hospitals continue to submit delayed hearing screening results via fax to the WSLH.

Wisconsin State Senate Bill 323 was passed during the 2009 legislative session. The bill requires the physician, nurse-midwife, or certified professional midwife who attends a birth to ensure that the infant is screened and that parents are advised of the results. Wisconsin Sound Beginnings, the State of Wisconsin's early hearing detection and intervention (EHDI) program, collaborated

with others on the revisions of the bill to include support for follow up services. This bill was signed into law in May 2010.

#### **a. Last Year's Accomplishments**

##### **1. Outreach/Public Education--Enabling Services--Pregnant women, mothers, and infants**

"Just in time" provider packets were sent upon diagnosis of a hearing loss. Survey results prompted the development of an EHDI materials sheet that was disseminated to the same target group. Several brochures have been updated or revised to reflect current follow-up protocols. A webinar was conducted and recorded to inform partners about increased focus on loss to follow-up at the state level and introduce new regional staff. New regional staff provide community education and direct hearing screening services for babies at risk for loss to follow-up.

##### **2. WI Sound Beginnings/Congenital Disorders Program--Population-Based Services--Pregnant women, mothers, and infants**

WSB coordinated follow-up with the WSLH and improved data quality. Risk factors are visible in WE-TRAC. A combined hearing and blood screening course was attended by out-of-hospital and home birth midwives as well as student midwives from WI and border states. WSB worked with the State Vital Records Office to include the Blood card number on the birth certificate to coordinate matching files for blood screening, hearing screening and birth records.

##### **3. Support Services for Parents--Enabling Services--Pregnant women, mothers, and infants**

The Statewide Parent Conference and professional preconference occurred. This years conference was notable due to the 14 families of deaf-blind children who attended as well as the families of children with hearing loss. Parent Follow-through position was hired to provide Guide By Your Side Follow-through support as well as 2 regional Parent Guides. Parent Guides began making direct phone calls to families of children at risk for loss to follow-up.

##### **4. Birth-3 Technical Assistance Network--Infrastructure Building Services--CYSHCN**

Audiologists made electronic referrals to Birth to 3 information system. Birth to 3 enrollment reports were generated.

##### **5. EHDI Workgroup--Infrastructure Building Services--CYSHCN**

The EHDI Quality Improvement Consortium decided not to meet formally as a large group but rather opted to form topic specific workgroups. The workgroups met related to specific issues such as tele-audiology and out of hospital support.

##### **6. Reduce Lost to Follow-up--Infrastructure Building Services--CYSHCN**

The creation of the WI EHDI Quality Improvement Toolkit was launched and replicated in MN. It was nationally recognized by earning the EHDI Website of the Year Award. The GBYS Follow-Through Program and WE-TRAC System continued to expand. 100% of hospitals used WE-TRAC by the end of 2010 as well as a number of out of hospital providers. WSB Program began defining new follow-up protocols and hiring and contracting staff with City of Milwaukee Health Department and Marshfield Clinic to conduct targeted outreach to families at risk for loss to follow-up. WSB also began investigating a collaboration with the WIC program to provide community targeted outreach and coordination of hearing screening.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Outreach/Public Education		X		
2. WSB/Congenital Disorders Program			X	
3. Support Services for Parents		X		
4. Birth-3 Technical Assistance Network				X
5. EHDl Workgroup				X
6. Reduce Lost to Follow-up				X
7.				
8.				
9.				
10.				

#### **b. Current Activities**

##### **1. Outreach/Public Education--Enabling Services--Pregnant women, mothers, and infants**

"Just in time" packets for providers are sent upon hearing loss diagnosis. An EHDl materials sheet is utilized to raise awareness of new and revised materials.

##### **2. WSB/Congenital Disorders Program--Population-Based Services--Pregnant women, mothers, and infants**

WSB coordinates follow-up with the WSLH. WSLH collected risk factors are now visualized in WE-TRAC. Continued educational opportunities for out of hospital providers on blood and hearing screening will be planned and executed.

##### **3. Support Services for Parents--Enabling Services--Pregnant women, mothers, and infants**

The annual Statewide Parent Conference and professional pre-conference is being planned in coordination with WSB. Regional parent guides contact families of babies that do not pass the hearing screen to encourage follow-up.

##### **4. Birth-3 Technical Assistance Network--Infrastructure Building Services--CYSHCN**

Babies identified with hearing loss will continue to be referred to Birth-3 via WE-TRAC.

##### **5. EHDl Workgroup--Infrastructure Building Services--CYSHCN**

The EHDl workgroup has been replaced by the Hearing Subcommittee of the Newborn Screening Umbrella Advisory Committee. This new group has met once and will meet again in October.

##### **6. Reduce Lost to Follow-up--Infrastructure Building Services--CYSHCN**

WSB has developed and implemented new regional follow-up including community hearing screening.

#### **c. Plan for the Coming Year**

##### **1. Outreach/Public Education--Enabling Services--Pregnant women, mothers, and infants**

"Just in time" packets for providers will continue to be sent upon hearing loss diagnosis along with the EHDl materials sheet. Changes to the DHS website will be made to incorporate hearing screening and blood screening information and materials.

##### **2. WSB/Congenital Disorders Program--Population-Based Services--Pregnant women, mothers, and infants**

WSB will continue to coordinate follow-up with the WSLH. WSLH collected risk factors will generate an action by WSB and providers since they are now visible in WE-TRAC. Continued educational opportunities for out of hospital providers on blood and hearing screening will be planned and executed. WSB will begin generating reports to the SLH for babies that have a hearing screening and/or a birth certificate but do not have a blood card record.

### 3. Support Services for Parents--Enabling Services--Pregnant women, mothers, and infants

The annual Statewide Parent Conference and professional pre-conference is being planned in coordination with WSB. Regional parent guides contact families of babies that do not pass the hearing screen to encourage follow-up. Parent Guides will also begin to call families of children diagnosed with hearing loss to assure their knowledge and understanding of the systems and services available to them.

### 4. Birth-3 Technical Assistance Network--Infrastructure Building Services--CYSHCN

Babies identified with hearing loss will continue to be referred to Birth to 3 via WE-TRAC. An Early intervention consent form will be constructed that will allow programs to share the enrollment information with the WSB program directly in a timely fashion. Parent Guides will be talking to families about the value of participating in the Birth to 3 program.

### 5. EHDI Workgroup--Infrastructure Building Services--CYSHCN

The Hearing Subcommittee of the Newborn Screening Umbrella Advisory Committee will continue to meet and provide guidance to the program.

### 6. Reduce Lost to Follow-up--Infrastructure Building Services--CYSHCN

WSB has developed and implemented a 3 step follow-up protocol that includes statewide outreach to the medical home, parent to parent support and coordinated community hearing screening done by regional outreach specialists at City of Milwaukee Health Department, Marshfield Clinic, and the DHS Family Health Section/MCHCYSHCN Program when necessary. WSB will work with the WIC projects to coordinate hearing screening outreach when families are in need and enrolled. WSB will also work with early Head Start and other home visitation programs to coordinate hearing screening follow-up.

## **Performance Measure 13:** *Percent of children without health insurance.*

### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	2.8	2.7	2.6	2.5	2.2
Annual Indicator	2.4	2.8	2.8	1.7	2.4
Numerator	31000	36000	36000	22000	31000
Denominator	1293000	1292000	1292000	1288854	1286000
Data Source		WI DHS/ OHI 2010.	WI DHS /OHI 2010.	WI DHS/OHI 2011.	WI DHS/OHI 2012.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer					

than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	2.2	2.1	2	2	2

#### **Notes - 2011**

Source: Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics, Family Health Survey, 2011 . Madison, Wisconsin: 2012. Numerator: Weighted data. Denominator: Weighted data.

Data issues: 1) Estimated numbers have been rounded to the nearest 1,000. The annual Wisconsin Family Health Survey is a random digit dial telephone survey that collects and reports information about health status, problems, insurance coverage, and use of health care services among Wisconsin residents. The survey has questions about health-related limitations and chronic conditions for persons greater than age seventeen.

#### **Notes - 2010**

Source: Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics, Family Health Survey, 2010 . Madison, Wisconsin: 2010. Numerator: Weighted data. Denominator: Weighted data.

Data issues: 1) Estimated numbers have been rounded to the nearest 1,000. The annual Wisconsin Family Health Survey is a random digit dial telephone survey that collects and reports information about health status, problems, insurance coverage, and use of health care services among Wisconsin residents. The survey has questions about health-related limitations and chronic conditions for persons greater than age seventeen.

The indicator 1.7% for 2010 is most likely a result of the expansion of Medicaid programs for children during the past two years, and we do not think it represents a trend given new program cuts. However, we will monitor this indicator closely. The subsequent year's objectives have been set with consideration of the forecast of program cuts for the next few years.

#### **Notes - 2009**

Source: Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics, Family Health Survey, 2010 . Madison, Wisconsin: 2009. Numerator: Weighted data. Denominator: Weighted data.

Data issues: 1) Estimated numbers have been rounded to the nearest 1,000. The annual Wisconsin Family Health Survey is a random digit dial telephone survey that collects and reports information about health status, problems, insurance coverage, and use of health care services among Wisconsin residents. The survey has questions about health-related limitations and chronic conditions for persons greater than age seventeen.

#### **a. Last Year's Accomplishments**

1. BadgerCare Plus Initiative--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

The Title V MCH/CYSHCN Program continued to support the BadgerCare Plus Program in the DHS/DHCAA that provides health insurance for all children in the state by working with partners throughout the state.

2. Support the "Covering Kids" Program--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

In cooperation with UW-Extension, the Title V MCH/CYSHCN Program continued to provide support for state and local coalitions that are promoting the use of the Covering Kids school outreach strategies tool kit. Covering kids & families (CKF) is a statewide coalition dedicated to reducing health disparities and improving overall health in Wisconsin by cultivating a network of

informed individuals and organizations and thereby enhancing capacity to maximize participation in public health insurance programs. These activities assist children and their families and build access to funding mechanisms through BadgerCare Plus for affordable, comprehensive health care coverage.

3. Wisconsin's Office of Free Market Health Care--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

On January 23, 2011, Governor Walker signed an executive order creating the Office of Free Market Health Care. The office was tasked with handling the state's response to new federal health care reform requirements and replaced the Office of Health Care Reform.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. BadgerCare Plus Initiative		X		
2. Support the "Covering Kids" Program		X		
3. Wisconsin's Office of Free Market Health Care		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

1. BadgerCare Plus Initiative--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

The MCH/CYSHCN Program is supporting the BadgerCare Plus Program to provide health insurance for all children in the state. The proposed changes to coverage will continue to support all children and pregnant women.

2. Support the "Covering Kids" Program--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

During 2012 strategies are being implemented from the Covering Kids Strategic Plan to assure all kids have health insurance coverage to meet prevention and chronic care needs.

3. Wisconsin's Office of Free Market Health Care--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

The MCH Program is working to assure connectedness to key provisions of the health care reform implementation that may impact MCH populations.

**c. Plan for the Coming Year**

1. BadgerCare Plus Initiative--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

The MCH/CYSHCN Program will continue to support the BadgerCare Plus Program to provide health insurance for all children in the state. The proposed changes to coverage will continue to support all children and pregnant women.

2. Support the "Covering Kids" Program--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

The Retention and Enrollment to Achieve Children's Health and Build Capacity (REACH BC+) is a project of Covering Kids & Families-Wisconsin which works with schools to be a vital link between Wisconsin residents and enrollment in BadgerCare Plus. REACH BC+ will continue to work through schools to enhance the capacity of schools to assist families in need of health insurance by increasing knowledge about BadgerCare + eligibility and enrollment, identify uninsured students and encourage enrollment in BadgerCare +.

3. Wisconsin's Office of Free Market Health Care--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

The MCH Program will continue to work to assure connectedness to key provisions of the health care reform implementation and its impact for MCH populations.

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	29	28	29.9	29.8	29.7
Annual Indicator	29.2	29.9	30.5	30.7	30.6
Numerator	15078	16707	18385	18412	18258
Denominator	51636	55875	60280	59975	59668
Data Source		CDC PedNSS 2009.	CDC PedNSS 2010.	CDC PedNSS 2010.	CDC PedNSS 2011.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	29.6	29.5	29.4	29.4	29.4

#### Notes - 2011

Source: 2011 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention. CDC is discontinuing the PedNSS. We will use an alternative sources for subsequent years.

#### Notes - 2010

Source: 2010 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention.

#### Notes - 2009

Source: 2009 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention.

#### **a. Last Year's Accomplishments**

##### **1. Increased Knowledge of Healthy Behaviors--Enabling Services--Children over the age of 2**

There are ~54 local coalitions that planned, implemented and evaluated evidence-based strategies promoting healthy eating, physical activity and healthy weight in all sectors. These activities include: a healthy fundraising/concession stand toolkit for schools, education on proper bike use for children, breastfeeding support groups and education, nutrition education at the farmers market, fruit and vegetable of the month promotion and promoting walk to school.

##### **2. Community Campaigns, Environment and Policy Change--Population-Based Services--Children over the age of 2**

LHDs and community coalitions implemented evidence-based strategies that resulted in changes to the nutrition and physical activity environment in their community. These included starting or expanding farmers markets, accepting EBT at the farmers market, raised funds for a playground for CYSHCN, became a breastfeeding friendly health department, assisted worksites to start worksite lactation programs and hospital breastfeeding policies, started childcare, school and community gardens, calorie labeling in restaurants and vending, sugar sweetened beverage policy in childcare, bike lanes and signage, snowshoe trails, safe routes to school program and farm to school programs

State Level work in early care and education included licensing commentary for physical activity minutes, wellness criteria in YoungStar, 20 childcare pilot sites adopting wellness policies, training to providers, and the development of the Active Early and Healthy Bites resource guides. Also, 21 pilot schools and 26 coalitions implemented strategies to promote 60 minutes of physical activity each day.

The Get Active initiative in two communities, as part of the Communities Putting Prevention to Work (CPPW) grant, included a county wide media campaign to support the implementation of multiple strategies including farm to school, calorie labeling in convenience and grocery stores, vending labeling, safe routes to school, social support, childcare, school and community gardens, complete streets policies, bike lane painting and signages, active commuting, healthy healthcare, afterschool programs and community mobilization for sustainability.

Prevention Speaks ([www.preventionspeaks.org](http://www.preventionspeaks.org)) was developed, through a CPPW grant, to train and mentor communities to use story telling as a strategy to increase awareness and action within the community. Several story packages were developed and are being used across the country. Some of the stories include: farm to school, community collaboration, community support agriculture at an opportunity jobs center for disabled adults, strong seniors, after school programs, point of decision prompts and many others.

##### **3. Needs Assessments and Plans--Infrastructure Building Services--Children over the age of 2**

LHDs are improving the nutrition and physical activity environment and building the infrastructure through community assessment processes, asset mapping, strategic planning, and sustainability planning. Through the CPPW grants 26 coalitions built capacity and skills in earned media, educating the public and decision makers and storytelling to increase physical activity. In addition, 2 communities mobilized their community through the Get Active initiative and implemented multiple strategies in multiple settings to address obesity.

##### **4. Nutrition and Physical Activity Coalitions - Collaboration and Partnerships--Infrastructure Building Services--Children over the age of 2**

Partnerships are vital to preventing obesity. The ~54 local coalitions focused on preventing obesity, improving nutrition and increasing physical activity had a variety of partners from public

health, advocacy, healthcare, media, schools, restaurants and grocery stores, private businesses, faith-communities, community-based organizations and private citizens. Coalitions worked across the levels of the social ecological model: individual (72%), interpersonal (51%), organizational (72%), community (57%), and policy (38%).

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increased Knowledge of Healthy Behaviors		X		
2. Community Campaigns, Environment and Policy Change			X	
3. Needs Assessments and Plans				X
4. Nutrition and Physical Activity Coalitions - Collaboration and Partnerships				X
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

##### **1. Increased Knowledge of Healthy Behaviors--Enabling Services--Children over the age of 2**

There are 54 local coalitions planning, implementing and evaluating evidence-based strategies that promote healthy eating, physical activity and healthy weight in all sectors. The activities are linked to the HW 2020 and the WI Nutrition and Physical Activity State Plan.

##### **2. Community Campaigns, Environment and Policy Change--Population-Based Services--Children over the age of 2**

LHDs and community coalitions are promoting nutrition and physical activity through campaigns such as Safe Routes to School, Screen Free Week, Farm-to-School, gardening, active environments, and earned media.

##### **3. Needs Assessments and Plans--Infrastructure Building Services--Children over the age of 2**

The second edition of the Wisconsin Nutrition, Physical Activity and Obesity State Plan will be released. The WALHDAB is developing a guide for LHDs to conduct community needs assessments and pilots. The 24 Community Transformation Grant communities will use the CDC CHANGE tool and conduct an assessment.

##### **4. Nutrition and Physical Activity Coalitions--Collaboration and Partnerships--Infrastructure Building Services--Children over the age of 2**

There are ~54 local coalitions focused on preventing obesity, improving nutrition and increasing physical activity.

#### **c. Plan for the Coming Year**

##### **1. Increased Knowledge of Healthy Behaviors--Enabling Services--Children over the age of 2**

LHDs and local coalitions will be provided with technical assistance and training to implement evidence-based strategies around six key health behaviors: increased breastfeeding, fruit and vegetable consumption, physical activity, and decreased television time, sugar-sweetened

beverage consumption and consumption of high energy dense foods. These activities will be linked to the Healthiest Wisconsin 2020 and the Wisconsin Nutrition Physical Activity and Obesity State Plan.

## 2. Community Campaigns, Environment and Policy Change--Population-Based Services--Children over the age of 2

LHDs and local coalitions will be encouraged to implement evidence-based strategies that improve the food and nutrition environment to make the healthy choice the easy choice. Such strategies may include; farm to school/childcare, joint use agreements, active schools, active early (childcare), breastfeeding friendly maternity care practices, healthier kids meals in restaurants, active community environments and social support campaigns. Strategies will be implemented in conjunction with other strategies (such as policy change, environmental change or education) and in various settings (early care, schools, worksites, community, healthcare) to increase the impact and reach. Awareness of and demand for healthy choices will be generated through educational opportunities, story telling and earned media.

## 3. Needs Assessments and Plans--Infrastructure Building Services--Children over the age of 2

The Nutrition, Physical Activity and Obesity Program will provide technical assistance to communities piloting the CHIPP process and the CTG communities and others using the CDC CHANGE tool to complete assessments. The Program will also support communities to develop, implement and evaluate the action plans developed as a result of the needs assessment.

## 4. Nutrition and Physical Activity Coalitions--Collaboration and Partnerships--Infrastructure Building Services--Children over the age of 2

State and community partnerships are vital to preventing and managing childhood overweight. There are ~54 local coalitions who are implementing evidence-based practices and environmental approach to prevent obesity. Through the Community Transformation Grant (CTG), 24 local communities are beginning work on farm to school and joint use agreements building toward comprehensive changes to the nutrition and physical activity environments. Key partners include: the UW Clearinghouse for Prevention, Departments of Public Instruction, Children and Families, Transportation and Agriculture, American Heart Association, Health First, UW-Extension, Minority Health Program, LHDs, and community coalitions.

### **Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	14	13.5	13.5	13.5	14
Annual Indicator	14.9	14.9	15.1	13.4	13.4
Numerator	10843	10843	10395	8793	8793
Denominator	72560	72560	68841	65684	65684
Data Source		WI DHS/BHIP 2009.	WI PRAMS, 2007- 2008.	WI PRAMS, 2009- 2010.	WI PRAMS. 2009- 2010.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	13.3	13	13	13	13

#### **Notes - 2011**

Data issue: These data are from Wisconsin PRAMS (Phase 6) and from the 2009 - 2010 weighted data set that is representative of Wisconsin resident mothers who had a live birth. The survey asks if moms smoked cigarettes in the past 2 years. If the moms answered yes, she's asked the quantity of cigarettes she smoked during the last 3 months of her pregnancy. The numerator represents those mothers who said they smoked during the last three months of pregnancy, and the denominator represents Wisconsin resident mothers.

#### **Notes - 2010**

Data issue: These data are from Wisconsin PRAMS (Phase 6) and from the 2009 - 2010 weighted data set that is representative of Wisconsin resident mothers who had a live birth. The survey asks if moms smoked cigarettes in the past 2 years. If the moms answered yes, she's asked the quantity of cigarettes she smoked during the last 3 months of her pregnancy. The numerator represents those mothers who said they smoked during the last three months of pregnancy, and the denominator represents Wisconsin resident mothers.

#### **Notes - 2009**

Data issue: These data are from Wisconsin PRAMS and from the 2007 - 2008 (Phase 5) weighted data set that is representative of Wisconsin resident mothers who had a live birth. The survey asks if moms smoked cigarettes in the past 2 years. If the moms answered yes, she's asked the quantity of cigarettes she smoked during the last 3 months of her pregnancy. The numerator represents those mothers who said they smoked during the last three months of pregnancy, and the denominator represents Wisconsin resident mothers.

### **a. Last Year's Accomplishments**

#### **1. First Breath--Enabling Services--Pregnant women, mothers and infants**

The Title V Program continued its First Breath Prenatal Smoking Cessation Program partnership with the Wisconsin Women's Health Foundation (WWHF). First Breath is a program that helps pregnant women in Wisconsin quit smoking by integrating cessation strategies into existing prenatal services including those provided by public health and private healthcare. In 2011, 1,460 women enrolled in the First Breath Program, bringing the total program enrollment to 11,629 since the statewide expansion in 2003. The majority of women (68%) enrolled in First Breath are non-Hispanic White, 80% are eligible for Medicaid, and 74% have a high school or less education level. Three months prior to getting pregnant, 0.4% of the women reported they were not smoking, 25% had already quit by the time of First Breath enrollment, 36% were not smoking prior to giving birth and 33% were not smoking postpartum. First Breath was awarded a grant from the Office on Women's Health to work with eight FQHCs on smoking cessation for women of childbearing age, to include a postpartum peer mentoring initiative. First Breath also began work on another federal grant focusing on smoking cessation services for Medicaid members.

#### **2. Prenatal Care Coordination--Enabling Services--Pregnant women, mothers and infants**

The Medicaid funded PNCC program provided services to approximately 10,000 eligible women. Assistance with smoking cessation is an expected services component of the PNCC program. The Wisconsin Women's Health Foundation provided training and technical assistance to the

PNCC providers to deliver the First Breath program. In 2011 per the SPHERE MCH data system representing 3,011 women, 47% of women reported smoking prior to pregnancy, 68% of those women continued to smoke during pregnancy, 75% of the women who smoked during pregnancy reported a decrease in smoking during pregnancy, and 39% of women reported others in the home were smoking. Of the 557 women who received MCH funded prenatal services 45% reported smoking prior to pregnancy, 65% of those women continued to smoke during pregnancy, 74% of the women who smoked during pregnancy reported a decrease in smoking during the pregnancy, and 45% of women reported others in the home were smoking. Per the 2010 Wisconsin Infant Birth and Death Report 14% of White, 16% of Black, 6% of Hispanic, 35% of American Indian, and 6% of Laotian/Hmong women smoked during pregnancy.

### 3. Preconception Services--Enabling Services--Pregnant women, mothers and infants

The Wisconsin Healthiest Women's Initiative (WHWI) in 2011 included a pilot project in the Milwaukee area with a woman's health clinic that integrated preconception education and interventions into already existing health services, including smoking cessation. The Wisconsin Association for Perinatal Care tool 'Prescription for a Healthy Future' was used on the medical record as a prompt to providers.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. First Breath		X		
2. Prenatal Care Coordination		X		
3. Preconception Services		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

##### 1. First Breath--Enabling Services--Pregnant women, mothers and infants

Currently, 110 First Breath sites are participating in the program. First Breath participants continue to be predominately of non-Hispanic white race, low income and low education level. Current activities include: focused recruitment of sites in southeastern Wisconsin that primarily serve Medicaid members and partnership with eight Federally-Qualified Health Centers. First Breath website ([www.wwhf.org](http://www.wwhf.org)) will be updated to include more educational resources for moms and healthcare providers, including videos.

##### 2. Prenatal Care Coordination--Enabling Services--Pregnant women, mothers and infants

WWHF First Breath staff are collaborating with MCH staff to provide training and technical assistance to PNCC providers to increase the number of available First Breath providers. This effort is concentrated in the southeast region of Wisconsin.

##### 3. Preconception Services--Enabling Services--Pregnant women, mothers and infants

The WHWI is continuing with interconception pilot projects with 1 Woman's Health Clinic in the Milwaukee area and 4 others around the state. The Medicaid HMO OB Medical Home Pilot completed 1 year of enrollment. Smoking cessation efforts are included in these initiatives.

Additionally through the Striving to Quit grant WHWI is focusing on services to women up to 1 year postpartum.

### c. Plan for the Coming Year

#### 1. First Breath--Enabling Services--Pregnant women, mothers and infants

The Title V Program will continue as a partner to accomplish the goals of the First Breath program. Future program focus will be on the following needs: invigorate and motivate participating clinicians; compete with other health care needs for limited clinician time; address clinical challenges (i.e. the risk for post-delivery relapse, unsupportive significant others, willingness to cut down but not quit, untruthful self-report, and failure to implement the agreed-to quit plan); and identify sustainable funding. First Breath will also work to increase enrollment within existing sites and continue expansion efforts statewide, with a particular focus on areas of the state with the highest rates of prenatal smoking and tribal clinics. In partnership with DPH, WHWI has agreed to expand First Breath to accommodate group prenatal care if WI is awarded a Strong Start Grant.

#### 2. Prenatal Care Coordination--Enabling Services--Pregnant women, mothers and infants

The WWHF will continue to collaborate with MCH to support existing First Breath/PNCC providers. Additionally efforts to develop and integrate group models and texting services will be completed and integrated with PNCC and the Health Plans.

#### 3. Preconception Services--Enabling Services--Pregnant women, mothers and infants

The WHWI will look for opportunities to expand interconception services into other women's health service areas. The Medicaid HMO OB Medical Homes will expand to other communities in Southern and Southeastern WI. Through the Striving to Quit grant expanded support and care coordination will be provided to women up to 1 year postpartum.

### **Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	9	8.7	8.6	8.5	8.5
Annual Indicator	7.7	6.7	10.1	10.5	10.5
Numerator	31	27	41	42	42
Denominator	402172	401148	405998	399209	399209
Data Source		WI DHS/OHI 2009.	WI DHS/OHI 2011.	WI DHS/OHI 2012	WI DHS/OHI 2012.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

	2012	2013	2014	2015	2016
Annual Performance Objective	10.4	10.4	10.3	10.3	10.2

#### Notes - 2011

Data issue: Data for 2011 will not be available from the Office of Health Informatics until 2013; therefore, the indicator for 2010 (10.5) are the data that we used for subsequent years' objectives. It is difficult to project annual objectives for this objectives because there the number of events are small compared to the population size, and the number of events randomly fluctuate.

#### Notes - 2010

Source: Wisconsin Department of Health and Family Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH), <http://dhfs.wisconsin.gov/wish/>, Mortality Module, accessed 04/27/2012.  
Data issue. Although there was an increase in 2009 to 41 deaths and in 2010 to 42 deaths by suicide from 27 deaths in 2009, we do not see a trend in an increased number of youth suicides. We will monitor this indicator closely for subsequent years, and since this rate may be adversely affected by a slight decrease or increase in the number of events, we have set out objectives based on our program expertise.

#### Notes - 2009

Source: Wisconsin Department of Health and Family Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH), <http://dhfs.wisconsin.gov/wish/>, Mortality Module, accessed 04/22/2011.

#### a. Last Year's Accomplishments

1. Anticipatory Guidance, Risk Assessment, and Referrals--Direct Health Care Services--Adolescents

MCH and Injury and Violence Prevention (IVP) staff and LHDs worked with partner groups to promote prevention, assessments, referrals and intervention.

2. Training and Presentations--Population-Based Services--Adolescents

Technical assistance continues on data and use of Burden of Suicide Report. Prevent Suicide WI (PSW) continues to support, train & do presentations for variety of audiences.

3. Prevent Suicide Wisconsin (PSW)--Infrastructure Building Services--Adolescents

Members of PSW worked with local agencies to build infrastructure within their communities as well as promote the development of other community coalitions and groups and support those who already had programs and activities in place.

4. Data--Infrastructure Building Services--Adolescents

The WI Violent Death Reporting System (WVDRS) collected, analyzed, and disseminated data on suicides, through the Wisconsin Interactive Statistics on Health (WISH).

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Anticipatory Guidance, Risk Assessment, and Referrals	X			
2. Training and Presentations			X	
3. Prevent Suicide Wisconsin (PSW)				X

4. Data				X
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

##### **1. Anticipatory Guidance, Risk Assessment, and Referrals--Direct Health Care Services--Adolescents**

MCH & IVP staff continue to work with partner groups to promote prevention, assessments, referrals & intervention. Four agencies chose the suicide prevention template objective for MCH contracting.

##### **2. Training and Presentations--Population-Based Services--Adolescents**

Technical assistance continues on data and use of Burden of Suicide Report. PSW continues to support, train & do presentations for variety of audiences.

##### **3. Prevent Suicide Wisconsin (PSW)--Infrastructure Building Services--Adolescents**

PSW has reapplied for Garrett Lee Smith funding. They continue to work with LHDs, and other partners to build infrastructure through coalition development and support those who already have programs and activities. Continued focus on carrying out improvements to enhance WI's overall infrastructure.

##### **4. Data--Infrastructure Building Services--Adolescents**

WVDRS continues to collect, analyze & disseminate data on suicides, including information for 15-19 year olds as in the past.

#### **c. Plan for the Coming Year**

##### **1. Anticipatory Guidance, Risk Assessment, and Referrals--Direct Health Care Services--Adolescents**

MCH and IVP staff work will continue to collaborate with community and professional groups to promote prevention, assessments, referrals and intervention. MCH Healthiest Families local objectives can be used for safety and injury prevention as well as mental health. Either can be used to develop a system around suicide prevention

##### **2. Training and Presentations--Population-Based Services--Adolescents**

WVDRS data will continue to be used to help guide local communities in planning efforts and outcomes of their work. PSW WI will continue to support and provide presentations and trainings to audiences.

##### **3. Prevent Suicide Wisconsin (PSW)--Infrastructure Building Services--Adolescents**

Prevent Suicide Wisconsin will continue to move forward with strengthening WI's overall infrastructure related to suicide prevention. Specific work is being completed to build local suicide prevention coalitions across the state. Additionally they are working on disseminating a statewide awareness campaign. Both MCH and IVP staff will continue to participate on the statewide coalition.

#### 4. Data--Infrastructure Building Services--Adolescents

WVDRS will continue to collect, analyze and disseminate data on suicides, including for 15-19 year old population as in the past. Additional data will be available through the Child Death Review System National Data Base as the Keeping Kids Alive Initiative is implemented with local public health departments.

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	82	82.5	76	76	90
Annual Indicator	75.8	86.0	89.8	90.0	90.0
Numerator	623	751	741	737	737
Denominator	822	873	825	819	819
Data Source		WI DHS/OHI 2010.	WI DHS/OHI 2010.	WI DHS/OHI 2012.	WI DHS/OHI 2012
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	90.5	90.5	91	91	91

#### Notes - 2011

Data issue: Data for 2011 will not be available from the Office of Health Informatics until 2013.

#### Notes - 2010

Source: Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics.

Data issue: In Wisconsin, hospitals self-designate level of care. Wisconsin does not have a regulatory function to stanrdize these self-designations. 95% confidence intervals are: 88.0%, 92.0%.

#### Notes - 2009

Source: Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics.

Data issue: In Wisconsin, hospitals self-designate level of care. Wisconsin does not have a regulatory function to stanrdize these self-designations. 95% confidence intervals are: 91.9%, 87.7%. For 2006 and 2007, Froedtert Hospital (one of the top 10 birthing centers in Wisconsin for number of deliveries) was not included as a facility for high-risk deliveries and neonates. For 2008 and subsequent years, births at Froedtert will be included. The Froedtert Birth Center is actually located within Children's Hospital; and infants born at Froedtert do have access to all services at Children's Hospital. We revised our objectives accordingly.

### a. Last Year's Accomplishments

#### 1. WI Association for Perinatal Care (WAPC) Efforts on Regionalization of Perinatal Care--Infrastructure Building Services--Pregnant women, mothers, infants

Hospitals in Wisconsin self-designate level of perinatal care. Wisconsin does not have regulatory function over the designations. WAPC has developed the Levels of Care Self-Assessment Initiative. Through the self-assessment, hospitals are given the opportunity to self-identify what level of perinatal service they provide, based on criteria that were adapted from the AAP levels of care--I, IIA, IIB, IIIA, IIIB, and IIIC. Level I provides well newborn care for infants and stabilizing care for infants of 35-37 weeks gestation and beyond; Level IIA provides care for preterm or ill infants requiring stabilization efforts and are either expected to recover rapidly or are awaiting transfer to another facility; Level IIB provides care at Level IIA plus mechanical ventilation for brief durations or continuous positive airway pressure; Level IIIA provides comprehensive care for infants born >28 weeks and weighing >1000gms and are able to provide life support and mechanical ventilation in addition to minor surgical procedures; Level IIIB provides comprehensive care for the extremely low birth weight infant (less than or equal to 28 weeks, 1000gms) with advanced respiratory support, full range of pediatric subspecialists, advanced imaging and surgical abilities; Level IIIC provides comprehensive care for premature infants at Level IIIB in addition to being able to provide ECMO and complex surgeries. The complete evaluation assessment process and tool can be located on the WAPC website ([www.perinatalweb.org](http://www.perinatalweb.org)). Sixty-two birthing hospitals have taken the self-assessment: 29 identified Level I; 8 identified Level IIA; 6 identified Level IIB; 2 identified Level IIIA; 12 identified Level IIIB; 1 identified Level IIIC and 4 are under review. An additional 39 hospitals offering prenatal services have not submitted a self-assessment. WAPC developed additional tools for parents explaining the levels of prenatal care (see [www.perinatalweb.org](http://www.perinatalweb.org)). The Levels IIIA and IIIB hospitals are primarily located in the southeastern part of Wisconsin. All five public health regions have a Level IIIA or Level IIIB facility.

#### 2. Medicaid Efforts on Prenatal Care Quality Improvement--Enabling Services--Pregnant women, mothers, infants

In collaboration with the MCH Program, Medicaid developed a criteria grid to measure the quality of prenatal care provided to all Medicaid women who have a poor birth outcome in the southeast region. The Healthy Birth Outcomes Care Guide is being used by the Metastar agency to audit prenatal records identified from the Medicaid High Risk Birth Registry and determine if a referral to the appropriate level of care was provided. The first year this audit is completed, results are not available yet. See Attachment IV.C - WI DHS Healthy Birth Outcomes Care Guide.

***An attachment is included in this section. IVC\_NPM17\_Last Year's Accomplishments***

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WAPC Efforts on Regionalization of Perinatal Care				X
2. Medicaid Efforts on Prenatal Care Quality Improvement		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

### b. Current Activities

1. WAPC Efforts on Regionalization of Perinatal Care--Infrastructure Building Services--Pregnant women, mothers, infants

WAPC continues to support the hospital self-assessment process for levels of perinatal care with outreach and guidance to both consumers and providers.

2. Medicaid Efforts on Prenatal Care Quality Improvement--Enabling Services--Pregnant women, mothers, infants

Medicaid continues to evaluate the quality of prenatal care services provided to women by the health plans and promote the appropriate level of care guidelines by the American Congress of Obstetricians and Gynecologists be followed as part of the Pay for Performance Initiative for Healthy Birth Outcomes.

**c. Plan for the Coming Year**

1. WAPC Efforts on Regionalization of Perinatal Care--Infrastructure Building Services--Pregnant women, mothers, infants

WAPC will continue to support the hospitals completing the self-assessment process for levels of perinatal care and to maintain the tools and educational materials on their website. The DPH plans to explore options for promoting the perinatal regionalization in collaboration with WAPC.

2. Medicaid Efforts on Prenatal Care Quality Improvement--Enabling Services--Pregnant women, mothers, infants

Medicaid will continue to evaluate the quality of prenatal care services provided to women by the health plans through the Pay for Performance Initiative for Healthy Birth Outcomes.

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	86.5	87	84	82	83.4
Annual Indicator	82.8	82.2	83.4	84.2	84.2
Numerator	60257	59217	59060	57595	57595
Denominator	72757	72002	70824	68367	68367
Data Source		WI DHS/OHI 2009.	WI DHS/OHI 2010.	WI DHS/OHI 2012.	WI DHS/OHI 2012.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	84.3	84.3	84.4	84.4	84.5

**Notes - 2011**

Data issue: Data for 2011 will not be available from the Office of Health Informatics until 2013; therefore, the indicator for 2010 (84.2%) are the data that we used for subsequent years' objectives which we determined reflect the difficulty of achieving a higher percentage of pregnant women entering first trimester prenatal care in Wisconsin.

**Notes - 2010**

Source: Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Births and Infant Deaths, 2010 (P-45364-10). January 2012.

**Notes - 2009**

Source: Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Births and Infant Deaths, 2009 (P-45364-09). May 2011.

**a. Last Year's Accomplishments****1. Title V Funded Perinatal Services--Enabling Services--Pregnant women, mothers, infants**

In 2011 MCH funded LHD template objectives to address prenatal individual services that reached 558 women. Of those, 43% initiated prenatal medical care in the first trimester, 31% had not started prenatal medical care yet. Of the women who initiated prenatal medical care in the first trimester, 45% delivered an appropriate for gestational age (AGA) weight infant and 45% delivered >37 weeks gestation. (Per the MCH SPHERE data system Prenatal Assessment Report and Postpartum Assessment and Infant Outcomes Report.)

**2. Prenatal Care Coordination (PNCC)--Enabling Services--Pregnant women, mothers, infants**

PNCC was included in the standards of practice for MCH funded Family Planning/Reproductive Health (FP/RH) agencies. The "Just the Basics" Practice Guidelines included the expectation that FP/RH providers either coordinated services with existing local PNCC providers or provide PNCC services directly to women seeking pregnancy confirmation and assistance at their clinics. MCH staff provided training and technical assistance to all FP/RH clinics at their annual conference. PNCC was integrated into the DCF Home Visiting/Family Foundations (MIECHV) program. MCH staff provided training and technical assistance to DCF funded and Children's Trust Fund home visiting programs. MCH staff provided regional PNCC provider network meetings in the 5 public health regions. In 2011 approximately 10,000 women received PNCC services. Data for 3011 of those women were captured in the MCH SPHERE data system identifying 60% initiated prenatal medical care in the first trimester and 25% had not started prenatal medical care yet. Of the women who initiated prenatal medical care in the first trimester, 56% delivered and AGA weight infant and 55% delivered >37 weeks gestation.

**3. Federal Healthy Start Projects in Wisconsin--Population-Based Services--Pregnant women, mothers, infants**

MCH staff served on the advisory committees for the Healthy Start projects. Both projects in WI participated in the Healthy Start ICC-LC with a focus on early entry into prenatal care.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title V Funded Perinatal Services		X		
2. Prenatal Care Coordination (PNCC)		X		
3. Federal Healthy Start Projects in Wisconsin			X	
4.				
5.				

6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

##### **1. Title V Funded Perinatal Services--Enabling Services--Pregnant women, mothers, infants**

In 2012 MCH funded template objectives to LHDs have moved to a systems approach, Early Child Systems. The Wisconsin Healthiest Families Initiative is focusing on 4 areas including family supports. The GLITC and additional tribal sites are participating in this initiative beginning this year. Through the Medicaid Medical Home OB Pilot Centering Pregnancy group prenatal care is being offered to pregnant women at a greater risk for late entry prenatal care. Additionally one tribal site is implementing Centering Pregnancy.

##### **2. Prenatal Care Coordination (PNCC)--Enabling Services--Pregnant women, mothers, infants**

Efforts to capture women seeking pregnancy confirmation at FP/RH clinics continue. DCF funded home visiting programs are initiating services prenatally to families. MCH staff is continuing to provide training and technical assistance to the clinics and home visitation programs, which includes several tribal sites, to support PNCC services to Wisconsin Medicaid recipients.

##### **3. Federal Healthy Start Projects in Wisconsin--Population-Based Services--Pregnant women, mothers, infants**

MCH continues to serve on the advisory committees for the Healthy Start projects which promote early entry into prenatal care. Through the MCH Early Childhood System, GLITC is incorporating the Life Course Framework.

#### **c. Plan for the Coming Year**

##### **1. Title V Funded Perinatal Services--Enabling Services--Pregnant women, mothers, infants**

Through the MCH Early Childhood Systems Initiative, LHDs and tribes will address family supports and preventive care at a systems level within their communities, while maintaining a focus on the Life Course perspective. If awarded the Strong Start grant, WI will add up to 6 additional sites for Centering Pregnancy, group prenatal care.

##### **2. Prenatal Care Coordination (PNCC)--Enabling Services--Pregnant women, mothers, infants**

PNCC will be integrated into all MCH funded FP/RH agencies at one of the acceptable standardized levels: 1) FP/RH agencies provide PNCC services directly to women, 2) FP/RH agencies establish a memorandum of understanding to provide initial screening and third trimester family planning services women receiving PNCC services within other local agencies, or 3) FP/RH agencies establish a strong referral relationship with existing PNCC providers. MCH staff will continue to provide training and technical assistance to these agencies as well as DCF home visitation programs, including tribal sites. MCH staff will continue to support regional PNCC provider meetings and collaboration with health plans to encourage early entry into prenatal medical care. MCH staff will work collaboratively with Medicaid to improve the reach of PNCC with revised guidelines and training to PNCC providers on Medicaid enrollment and working with 'hard to reach' families.

## D. State Performance Measures

**State Performance Measure 1:** *Percent of eligible women enrolled in the Wisconsin Medicaid Family Planning Waiver during the year.*

### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	24	26	21	22	25
Annual Indicator	21.1	20.3	24.0	25.3	24.3
Numerator	59799	57459	67883	71524	68757
Denominator	282970	282970	282970	282970	282970
Data Source		WI DHS/DHCAA 2009.	WI DHS/DHCAA 2009.	WI DHS/DHCAA 2010.	WI DHS/DHCAA, Policy Research 2012.
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	25	25	25	25	25

#### Notes - 2010

Objectives are held at level at 25% for 2011-2015. Wisconsin has proposed to eliminate GPR-Family Planning funding in 2011, which supports the statewide system of community based family planning services, through which over 75% of Medicaid family planning services are provided. Accurate projections are impossible due to uncertainty of impact. Statewide access is likely to decrease.

#### Notes - 2009

The federal Deficit Reduction Act (DRA) implemented several provisions that resulted in decreased enrollment in all Medicaid programs, including the Family Planning Waiver; we have revised objectives accordingly.

#### a. Last Year's Accomplishments

##### 1. Outreach and Enrollment--Enabling Services--Women of Reproductive Age

Beginning in 2011, many family planning services under contract with DHS had the capacity to facilitate enrollment through web-based electronic applications rather than paper-based enrollment forms. Community based providers actively assist enrollees with required verifications and documentation to support faster determination of eligibility and enrollment. Qualified family planning health providers have the capacity to temporarily enroll eligible men and women, and provide same-day/same-visit services and supplies.

The MCH Program released updated Women's Health/Perinatal Guidelines (patient care and administration), standards of practice, and quality assurance/performance indicators to improve outreach, eligibility screening and enrollment, quality and comprehensiveness of care, and patient responsive care (for improved patient satisfaction and convenience) in September 2011. These guidelines were released to community based family planning providers and available to federally qualified health center in Wisconsin. Health insurance eligibility screening and enrollment

continues as a core standard of practice.

The Milwaukee Adolescent Pregnancy Prevention Partnership (MAPPP) promotes outreach and enrollment in the WI Medicaid Family Planning Only benefit. In 2011, the MAPP initiative was combined with the new PREP Grant. See NPM 8.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreach and Enrollment		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

**1. Outreach and Enrollment--Enabling Services--Women of Reproductive Age**

The Wisconsin Legislature may consider options regarding the future of community-based family planning clinics services, and future Medicaid family planning services. Funding for the community-based family planning program, through which over 75% of Medicaid family planning services are provided is uncertain. Accurate projections of future outreach and enrollment (based on past performance and eligibility criteria) are not possible due to uncertainty of the impact of policy decisions.

The MAPP initiative-like expansion in Racine and Beloit is under development.

**c. Plan for the Coming Year**

**1. Outreach and Enrollment--Enabling Services--Women of Reproductive Age**

The MCH Women's Health-Family Planning Program will promote a "managed enrollment" initiative. Community-based providers will receive technical assistance and support to actively engage with and facilitate patient enrollment into the Badger Care-Family Planning Only Service Program. This will include providing assistance to patients in initiating enrollment applications, and submitting the required documentation to complete enrollment.

Contractual agreements will be established in the cities of Racine and Beloit to expand the MAPP Initiative.

**State Performance Measure 2: *Percent of children who receive coordinated, ongoing comprehensive care within a medical home.***

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2007	2008	2009	2010

<b>Data</b>				
Annual Performance Objective	52.5	53	53.5	55
Annual Indicator	52.5	62.9	62.9	62.9
Numerator	694021	799738	799738	799738
Denominator	1321945	1271037	1271037	1271037
Data Source		NatlSurChlHlth/NCHS/CDC.	NatlSurChlHlth/NCHS/CDC.	NatlSurChlHlth/NCHS/CDC
Is the Data Provisional or Final?				Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
Annual Performance Objective	64	64	65	65

#### **Notes - 2011**

Source: 2007 National Survey of Children's Health, National Center for Health Statistics, Centers for Disease Control and Prevention.

#### **Notes - 2010**

Source: 2007 National Survey of Children's Health, National Center for Health Statistics, Centers for Disease Control and Prevention.

#### **Notes - 2009**

Source: 2007 National Survey of Children's Health, National Center for Health Statistics, Centers for Disease Control and Prevention.

#### **a. Last Year's Accomplishments**

##### **1. Reproductive Health and Prenatal Care Coordination--Enabling Services--Infants**

The MCH program continues to promote Medicaid PNCC services for prenatal and postpartum care with a goal of establishing medical home for infants. In 2011 17% of eligible women received PNCC.

##### **2. Early Screening--Population-Based Services--Infants and Children**

The WI Statewide Medical Home Initiative (WISMHI) is funded as a CYSHCN hub for Medical Home implementation. In 2011 75 PCPs received training on ASQ 3 and M-CHAT. The hub promotes developmental and autism screening and Medical Home role in early hearing screening. Working with Waisman Center, a database of practices engaged in Medical Home activities is used. A WI EHDI tool kit promotes Medical Home strategies to reduce lost-to-follow-up. The State's ASD Implementation grant created a series of Medical Home webcasts to provide general information on Medical Home, developmental screening, EHDI and other topics ([www.waisman.wisc.edu/connections/webcast.php](http://www.waisman.wisc.edu/connections/webcast.php)). Contracts with Congenital Disorder diagnostic and treatment centers continued to support Medical Home implementation strategies (care planning including transition to adult health services, co-management with specialty care/Medical Home, and linkages to services). Additional details are available under NPM 3.

##### **3. Oral Health--Population-Based Services--Children and CYSHCN**

The WI Oral Health Program continued to provide technical assistance and guidance to CHAW to administrator a HRSA grant whose goals were to promote oral health as a part of total health for CYSHCN and to organize community resources to increase access to dental care for CYSHCN.

The Seal-A-Smile School based and linked dental sealant program provided 3,633 CYSHCN dental services during the 2010-2011 school year including dental sealants, screenings and fluoride varnish application.

#### 4. Early Childhood Comprehensive Systems--Infrastructure Building Activities--Young Children

The year 2 ECCS continuation grant continued to work on the five components of a system of services for young children including screening programs and the promotion of Medical Home in 2011. Work continued with AAP on implementing Bright Futures as part of LHDs' standard practices in collaboration with community partners through a media site web training continued through 2010 which also supported the Medical Home initiative for children.

#### 5. Project LAUNCH Grant--Population-Based Services--Young Children ages 0-8

Project LAUNCH worked directly with medical providers in the City of Milwaukee to provide them technical assistance and support around early identification of developmental delays and integrating behavioral health into primary care. LAUNCH is also working with state and community partners including the State's MCH/CYSHCN and ECCS Programs to promote the early identification of developmental delays and the integration of behavioral health into primary care statewide through related systems development.

#### 6. Medical Home - Foster Care--Direct Care Services--Children ages 0-21

In 2011, the State of Wisconsin submitted a State Plan Amendment to CMS, proposing a Foster Care Medical Home (FCMH) program be implemented in southeast Wisconsin in 2012. The general intent of the FCMH program is to offer comprehensive, coordinated services for Wisconsin's children in foster care. Specific goals of the FCMH program include: 1) Integrated Health Service Delivery, 2) Access and Comprehensiveness, 3) Continuity and Coordination of Care, 4) Transitional Planning, 5) Consumer Satisfaction, and 6) Well-Being Outcomes.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Reproductive Health/Prenatal Care Coordination		X		
2. Early Screening			X	
3. Oral Health			X	
4. Early Childhood Comprehensive Systems				X
5. Project LAUNCH Grant			X	
6. Medical Home - Foster Care	X			
7.				
8.				
9.				
10.				

#### **b. Current Activities**

##### 1. Reproductive Health/Prenatal Care Coordination--Enabling Services--Infants

MCH promotes PNCC as a comprehensive program for women's health including a focus on establishing a medical home.

##### 2. Early Screening--Population-Based Services--Infants and Children

WISMHI continues to receive funds as the MH "hub of expertise" to work with pediatricians and partners.

### 3. Oral Health--Population-Based Services--Children and CYSHCN

The oral health services provided to CYSHCN as a result of the HRSA grant are integrated into the health department or agencies employing ROHC.

### 4. Early Childhood Comprehensive Systems--Infrastructure Building Activities--Young Children

ECCS year 3 continuation funds are being used to continue the work of state partners on the 5 components of ECCS including integrating Bright Futures within LHDs and other statewide early childhood systems initiatives.

### 5. Project LAUNCH Grant--Population-Based Services--Young Children ages 0-8

Project LAUNCH Activities are ongoing.

### 6. Medical Home - Foster Care--Direct Care Services--Children ages 0-21

The Foster Care Medical Home initiative was implemented.

## **c. Plan for the Coming Year**

### 1. Reproductive Health and Prenatal Care Coordination--Enabling Services--Infants

MCH will continue to promote PNCC as a comprehensive program for prenatal and postpartum care with a goal of including a focus on establishing Medical Home for mothers and infants.

### 2. Early Screening--Population-Based Services--Infants and Children

CYSHCN Program contracts with Northeast Regional Center as the lead for CYSHCN Medical Home activities. Planned activities include a continued effort to promote the Medical Home educational materials and webcasts among partners. WIMHI will utilize WISC-U, the common database of practices engaged in early identification/Medical Home activities. Congenital Disorder Program contracts will continue coordination with the child's Medical Home including transition planning and linkages to the Regional Centers and CYSHCN Collaborators Network.

### 3. Oral Health--Population-Based Services--Children and CYSHCN

Children's Health Alliance of WI and the Wisconsin Oral Health Program are committed to oral health for CYSHCN and will continue to provide technical assistance and guidance. TA and training of student and practicing dental providers in professional education programs, FQHCs and other safety net dental clinics will continue as an effective dental treatment education model.

### 4. Early Childhood Comprehensive Systems--Infrastructure Building Activities--Young Children

In 2013, the MCH Program will work with state and local partners to enhance the reach and impact of ECCS funds and activities to impact the early childhood system in Wisconsin. In planning and implementation, enhanced focus will be placed on aligning ECCS activities with Project LAUNCH and MIECHV Program activities to increase collaborations and impacts.

### 5. Project LAUNCH Grant--Population-Based Services--Young Children ages 0-8

LAUNCH will continue to work with medical providers to improve and increase early intervention of developmental delays with medical providers in the City of Milwaukee and LAUNCH will work to share lessons learned throughout the state. LAUNCH will also continue to work with medical providers to support their efforts to integrate behavioral health into primary care and will explore

opportunities to expand that integration throughout the state.

#### 6. Medical Home - Foster Care--Direct Care Services--Children ages 0-21

Establishing medical homes for children in foster care is a priority for DHS.

### **State Performance Measure 3:** *Percent of Black, non-Hispanic women who have had a live birth who report symptoms of depression after pregnancy.*

#### Tracking Performance Measures

[Secs 485 (2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					25
Annual Indicator		25.5	25.5	25.5	16.4
Numerator		1795	1795	1795	1129
Denominator		7031	7031	7031	6879
Data Source		WI PRAMS.	WI PRAMS, 2007-2008.	WI PRAMS, 2009-2010.	WI PRAMS, 2009-2010.
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	25	23	23	22	22

#### **Notes - 2011**

Source: These data are from Wisconsin PRAMS (Phase 6) and from the 2009 - 2010 weighted data set that is representative of Wisconsin resident mothers who had a live birth. These data are not comparable to previous years' data because the question was asked differently. Phase 7 data, which will be available in 2013, will be comparable to previous years. Therefore, we did not change our objectives.

#### **Notes - 2010**

Source: These data are from Wisconsin PRAMS (Phase 6) and from the 2009 - 2010 weighted data set that is representative of Wisconsin resident mothers who had a live birth. These data are not comparable to previous years' data because the question was asked differently. Phase 7 data, which will be available in 2013, will be comparable to previous years. Therefore, we did not change our objectives.

#### **Notes - 2009**

Source: These data are from Wisconsin PRAMS and from the 2007 - 2008 (phase 5) weighted data set that is representative of Wisconsin resident mothers who had a live birth. The survey asks: 1) Since your new baby was born, how often have you felt down, depressed, or hopeless? And, 2) Since your new baby was born, how often have you had little interest or little pleasure in doing things? Postpartum depression was defined by a response of "always" or "often" to either one of these questions.

Data issue: Data from the 2009 - 2010 data set will not be available until 2012.

#### **a. Last Year's Accomplishments**

##### 1. PRAMS--Infrastructure Building Services--Pregnant women, mothers, infants

In 2011 the MCH program shared the PRAMS information on the disparities in women experiencing depression symptoms. PRAMS information on depression and stress by race and ethnicity was used by participants of the Wisconsin Healthiest Women's Initiative to select the

focus areas. In 2011 16.4% of Black, non-Hispanic women reported experiencing symptoms of depression since the birth of a new baby. PRAMS data used to assess postpartum depression in African American mothers who had a live birth were collected (phase 6) and analyzed differently from the previous version (phase 5) and data reported for 2008-2009 (2010 data were updated). The more recent data (2010 and 2011) reflect mothers' responses to one question and the selection of up to three choices with points assigned for each choice; a total of 10 points was used to measure postpartum depression.

**2. Wisconsin Task Force on Perinatal Depression--Infrastructure Building Services--Pregnant women, mothers, infants**

This multi-disciplinary task force consisting of public, private, academic partners, and consumers distributed the revised MCH's "More than Just the Blues" brochure including information on risk factors, self-treatment, and screening for risk of perinatal mood disorders.

**3. WI Healthiest Families Initiative (WHFI)--Population-Based Services--Infant and Children**

The WHFI was implemented with LHDs to support a system of services related to mental health as well as family supports, child development and safety and injury prevention. LHDs began assessments to identify the services, programs, and resources in the community that address the mental health and social emotional wellness of infants and children, and their parents and families.

**4. Prenatal Care Coordination (PNCC)--Direct Services--Pregnant women, mothers, infants**

In 2011 58.3% of women receiving services through PNCC, home visiting and MCH programs were screened for depression; of those identified as at risk for depression, 57% were referred for treatment and services, 21% were already receiving services per WI SPHERE.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. PRAMS				X
2. Wisconsin Task Force on Perinatal Depression				X
3. WI Healthiest Families Initiative (WHFI)			X	
4. Prenatal Care Coordination (PNCC)	X			
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

**1. PRAMS--Infrastructure Building Services--Pregnant women, mothers, infants**

PRAMS data on the disparities in women experiencing depression symptoms is being used by the Wisconsin Healthiest Women's Initiative.

**2. Wisconsin Task Force on Perinatal Depression--Infrastructure Building Services--Pregnant women, mothers, infants**

The Task Force has applied for grant funding to support a collaborative effort with the Department of Children and Families (DCF) to provide intensive training to home visitors on mother and child

support groups. This effort will be piloted in 3-4 home visiting projects. This effort will incorporate the Infant Mental Health Endorsement and Certificate program graduates. Additionally the Task Force is distributing information at the Wisconsin Women's Health Summit to increase awareness of depression screening.

### 3. WI Healthiest Families Initiative (WHFI)--Population-Based Services--Infant and Children

Five LHDs have selected the WHFI Mental Health MCH objective for 2012.

### 4. Prenatal Care Coordination (PNCC)--Direct Services--Pregnant women, mothers, infants

The MCH Program is working with Medicaid PNCC providers to screen pregnant and postpartum women for depression.

## c. Plan for the Coming Year

### 1. PRAMS--Infrastructure Building Services--Pregnant women, mothers, infants

The MCH Program will continue to support the sharing of PRAMS data on the disparities in women experiencing depression symptoms and other contributing social determinants to report on the Wisconsin Healthiest Women Initiative (WHWI).

### 2. Wisconsin Task Force on Perinatal Depression--Infrastructure Building Services--Pregnant women, mothers, infants

The Task Force will work to increase awareness of postpartum depression with a Governor Proclamation. Additionally the Task Force will provide training to DCF funded home visiting projects to improve the effectiveness of screening and interventions with high risk women and families. The group support model will be piloted in home visiting projects, incorporating the competencies of infant mental health, with intent to implement the model in all DCF funded home visiting programs.

### 3. WI Healthiest Families Initiative (WHFI)--Population-Based Services--Infant and Children

The MCH Program will continue to work with LHDs who are focusing on mental health for their ECS objectives. Training and technical assistance will be provided in collaboration with the Wisconsin Alliance for Infant and Child Mental Health.

### 4. Prenatal Care Coordination (PNCC)--Direct Services--Pregnant women, mothers, infants

The number of women receiving depression screening and referral for services by PNCC providers will be monitored through WI SPHERE. Training on depression screening is planned statewide for home visiting/PNCC providers focusing on the prenatal and early postpartum period.

## State Performance Measure 4: *Percent of women who have had a live birth who report having an unintended or unwanted pregnancy.*

### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					34
Annual Indicator		35.4	35.4	37.6	37.6

Numerator		24382	24382	24604	24604
Denominator		68841	68841	65374	65374
Data Source		WI PRAMS.	WI PRAMS, 20076-2008.	WI PRAMS, 2009-2010.	WI PRAMS 2009-2010.
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	34	33	33	33	33

#### **Notes - 2011**

Source: These data are from Wisconsin PRAMS (Phase 6) and from the 2009 - 2010 weighted data set that is representative of Wisconsin resident mothers who had a live birth. The survey asks: 1) Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant? Unintended or unwanted pregnancy was defined by a response of "I wanted to be pregnant later" or "I didn't want to be pregnant then or at any time in the future."

#### **Notes - 2010**

Source: Source: These data are from Wisconsin PRAMS (Phase 6) and from the 2009 - 2010 weighted data set that is representative of Wisconsin resident mothers who had a live birth. The survey asks: 1) Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant? Unintended or unwanted pregnancy was defined by a response of "I wanted to be pregnant later" or "I didn't want to be pregnant then or at any time in the future."

#### **Notes - 2009**

Source: These data are from Wisconsin PRAMS and from the 2007 - 2008 weighted data set that is representative of Wisconsin resident mothers who had a live birth. The survey asks: 1) Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant? Unintended or unwanted pregnancy was defined by a response of "I wanted to be pregnant later" or "I didn't want to be pregnant then or at any time in the future." Data issue: Data from the 2009 - 2010 data set will not be available until 2012.

#### **a. Last Year's Accomplishments**

##### **1. PRAMS--Infrastructure Building Services--Pregnant women, mothers, infants**

In 2010 and 2011 PRAMS data 37.6% of women reported wanting their pregnancy either later or not at all. This information was shared with PNCC, WIC, Home Visiting, and Health Plan providers/partners.

##### **2. Women's Health Now and Beyond Pregnancy--Enabling Services--Pregnant women, mothers, infants**

Women's Health Now and Beyond Pregnancy, has been implemented as core services in the Family Planning Reproductive Health (FP/RH) Program contracts and with the Medicaid HMO contracts for the Southeast Region Pay for Performance Initiative. This service to women during pregnancy supports postpartum contraceptive services and healthy child spacing. 2011 SPHERE prenatal data reports 41% of women receiving prenatal services desired pregnancy later or not at all. The MCH Program provided training and technical assistance to promote strengthening relationships between FP/RH providers and PNCC providers to enable women to obtain third trimester contraceptive supplies and services and continue services during the interconception period.

##### **3. Healthy Start Interconception Care Learning Community--Infrastructure-Building Services--Pregnant women, mothers, infants**

Great Lakes Inter-Tribal Council's Honoring Our Children (HOC) project participated in the

Healthy Start Interconception Care Learning Community (ICC-LC) and focused on reproductive health. Their aim in the first cycle was to increase the number of healthy birth outcomes by providing women with family planning education, resources and referrals to help them attain their desired spacing between pregnancies. A reproductive health kit was developed for HOC participants. The 2nd change project implemented reproductive life plans with 25% of HOC interconceptional participants. The final cycle of the ICC-LC focused on active referrals to primary providers for contraceptive supplies and services. An MCH representative served on the HOC team participating in the Healthy Start ICC-LC.

4. Wisconsin Healthiest Women Initiative--Infrastructure-Building Services--Pregnant women, mothers, infants

In 2011 the MCH Program in collaboration with partners piloted pre and interconception activities in women's health clinics (See HSI 1A-2B). Additionally in partnership with leaders across the state working in women's health the MCH Program convened partners to identify and address issues in women's preconception health. In the second forum Sexual Health and Pregnancy Planning and Socioeconomic and Environmental Determinants of Health were identified as the focus areas for the Framework for the Wisconsin Healthiest Women Initiative. This democratic selection process was guided by the sharing of data from PRAMS and BRFSS along with community feedback from the 4 Lifecourse Initiative for Healthy Families (LIHF) collaboratives of Southern and Southeastern Wisconsin.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. PRAMS				X
2. Women's Health Now and Beyond Pregnancy		X		
3. Wisconsin Healthiest Women Initiative				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

1. PRAMS--Infrastructure Building Services--Pregnant women, mothers, infants

The MCH Program continues to share PRAMS data with partners around the state.

2. Women's Health Now and Beyond Pregnancy--Enabling Services--Pregnant women, mothers, infants

The MCH Program is working with Health Care Education and Training (HCET) to implement a phase 2 of Women's Health Now and Beyond Pregnancy to include additional interconception services. This will be implemented in 4 FP/RH clinics.

3. Wisconsin Healthiest Women Initiative--Infrastructure-Building Services--Pregnant women, mothers, infants

The MCH Program will be convening partners together to share Wisconsin's Statewide Framework for Improving Women's Health. Additionally, MCH is developing a website in collaboration with partners to provide resources to communities, health systems, education

systems, public and private partners, and consumers, on preconception health for women and men of childbearing age.

### c. Plan for the Coming Year

#### 1. PRAMS--Infrastructure Building Services--Pregnant women, mothers, infants

During 2013 the MCH Program will continue to support sharing PRAMS results with both internal and external partners at meetings and conferences promoting data driven and evidence based programming.

#### 2. Women's Health Now and Beyond Pregnancy--Enabling Services--Pregnant women, mothers, infants

Women's Health Now and Beyond Pregnancy will continue to be the standard of care for FP/RH and PNCC providers, increasing the number of women receiving contraceptive supplies prior to delivery and implementing a reproductive life plan. In collaboration with Medicaid, the MCH Program will continue to promote the provision of third trimester contraceptive supplies as part of the Medicaid Pay For Performance Initiative. The MCH Program will continue to support pilot projects and identify opportunities to share outcomes and promote the integration of pre- and interconception services to women into existing public and private clinical settings.

#### 3. Wisconsin Healthiest Women Initiative--Infrastructure-Building Services--Pregnant women, mothers, infants

The MCH Program will continue to build on the Framework for Action to Eliminate Racial and Ethnic Disparities in Birth Outcomes and the Women's Health Now and Beyond Pregnancy pilot project with the distribution of the Wisconsin's Statewide Framework for Improving Women's Health. Additionally the MCH Program will continue to work with statewide partners to move pre and interconception pilot outcomes and lessons learned to additional women's health care settings and across programs within DPH and DHS.

### **State Performance Measure 5:** *Rate per 1,000 of substantiated reports of child maltreatment to Wisconsin children, ages 0 - 17, during the year.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	6	6	6	6	3.6
Annual Indicator	5.0	3.6	4.0	4.0	4.0
Numerator	6721	4685	5207	5237	5237
Denominator	1353148	1314412	1314412	1310250	1310250
Data Source		WI DCF 2009.	WI DCF 2010.	WI DCF 2012.	WI DCF 2012.
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	3.6	3.5	3.5	3.4	3.4

#### **Notes - 2011**

Data issue: Data for 2012 are not available from the 'Wisconsin Department of Children and Families until fall 2012 or early 2013.

## Notes - 2010

Data issue: Data for 2010 are not available from the Wisconsin Department of Children and Families until fall 2011 or early 2012.

## Notes - 2009

Source: Wisconsin Child Abuse and Neglect Report. Annual Report for Calendar Year 2009 to the Governor and Legislature. December 2010.

### a. Last Year's Accomplishments

1. Department of Children & Families (DCF)- Home Visiting Programs--Enabling Services--Infants and Young Children and their families

The MCH Program continued to support the DCF home visiting program as they transitioned into the new funding cycles including Maternal and Infant Early Childhood Home Visiting (MIECHV). The DCF Home Visiting Program has multiple goals, including impact on birth outcomes, improving health and family outcomes and importantly decreasing child abuse and neglect in Wisconsin. MCH Program staff provided support and leadership through the RFP process. The new DCF Home Visiting program, Family Foundations, blended previously separate home visiting dollars from TANF and state general purpose revenues with the ACA federally funded MIECHV Program. In 2011, with support and staff leadership from the MCH Program, the Family Foundations RFP was developed and released by the DCF. Through the RFP process, and subsequent competitive grant award to Wisconsin, DCF funded eleven evidence-based home visiting programs across the state. The new funding cycle began in summer and fall of 2011. The funded projects are located in the at-risk communities identified through the collaborative needs assessment process completed as a requirement of the MIECHV funding. The projects that were funded represent a mix of models including Healthy Families America, Early Head Start Home-Based Option and Nurse Family Partnership. The sites exist in urban, rural and Tribal communities. All of these models seek to decrease child abuse and neglect in the families that they serve. As sites made the transition into this new funding stream and cycle, and the new implementation guidelines and benchmark reporting that is a part of MIECHV, MCH staff provided critical insight, support and technical assistance.

2. Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program--Enabling Services--Infants and Young Children and their families

The State MCH Program provided leadership and guidance as the mechanism for collecting and reporting of the requirements for the MIECHV Program were developed. Interviews for the Home Visiting Nurse Consultant position were held with department approval to hire at the start of the upcoming year (1/2012). MCH worked with DCF and partners crosswalking MIECHV reporting requirements and fields in MCH's data system, SPHERE.

3. Provide support for Together for Children conference--Population-Based Services--Infants and Young Children and their families

The MCH Program provided assistance to conference planning for the annual child abuse conference held by Prevent Child Abuse Wisconsin, Together for Children. The conference provides a wide variety of sessions geared at various skill levels targeting professionals and paraprofessionals in the prevention field.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. DCF-funded Home Visiting Programs including Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program		X		

2. Provide support for Together for Children conference			X	
3.				
4.				
5.				
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7.				
8.				
9.				
10.				

#### **b. Current Activities**

1. DCF-funded Home Visiting Programs including Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program--Enabling Services--Infants and Young Children and their families

Januray, 2012, the Home Visiting (HV) Nurse Consultant position was filled and will strengthen the connection between the MCH Program and the MIECHV Program at DCF. MCH staff, along with the HV Nurse Consultant, are actively involved with the planning, data collection and processes, and evaluation of the MIECHV Program. The Home Visiting Nurse Consultant is coordinating with DCF staff in the oversight and implementation of the home visitation program providing trainings and TA, and site visits. The program is now in full implementation with eleven funded projects in at-risk communities across the state that is expected to serve approximately 1200 families annually. The MCH Program plans to continue to provide leadership, time and resources to improving SPHERE for the home visiting projects.

2. Provide support for Together for Children conference--Population-Based Services--Infants and Young Children and their families

The MCH Program continues to provide planning support for the Together for Children conference.

#### **c. Plan for the Coming Year**

1. DCF Home Visiting Programs including Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program--Enabling Services--Infants and Young Children and their families

During 2013, the MCH Program will continue to provide support to the DCF MIECHV Program as it impacts the MCH population of women, infants, children and families in the identified at-risk communities. As MIECHV requirements continue to be implemented, the State MCH Program will continue to provide leadership to assure all programs within their oversight are strongly represented in these efforts and integration opportunities are encouraged. The Home Visiting Nurse Consultant will continue to strengthen the collaboration between the MCH Program and the Home Visiting Program at DCF and other partners. She will provide leadership in planning and implementation of evidence-based home visiting models, technical assistance to sites, and development/provision of training. SPHERE will continue to be updated as needed. Work will be done to continually improve data collection procedures as well as improve data use and analysis for program continuous quality improvement.

2. Provide support for Together for Children conference--Population-Based Services--Infants and Young Children and their families

The MCH Program plans to again support the Together for Children conference with planning support and attendance of staff. Together for Children is an annual conference focused on efforts to prevent child abuse in Wisconsin and support service providers who provide child abuse

victims with treatment.

**State Performance Measure 6:** *Percent of children age 10 months to 5 years who received a standardized screening for developmental or behavioral problems.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					30
Annual Indicator		25.9	25.9	25.9	25.9
Numerator		87900	87900	87900	87900
Denominator		338982	338982	338982	338982
Data Source		NSCH, NCHS, CDC, 2007.	NSCH, NCHS, CDC, 2007.	NSCH, NCHS, CDC, 2007.	NSCH, NCHS, CDC, 2007.
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	30	30	33	33	33

**a. Last Year's Accomplishments**

1. Developmental screening of young children--Direct Health Care--Children including CYSHCN

The State MCH Program continued to promote connected and comprehensive systems of early childhood for all children that included developmental screening using a valid, reliable tool that supports both provider practice and parental knowledge. State public health programs report in SPHERE developmental screening results using the ASQ-2 and ASQ-3 tools and track outcomes of a plan for intervention if indicated. During 2011, 3,591 unduplicated developmental screens using ASQ-2 and ASQ-3 tools were reported in SPHERE for children up to age 5 years. Of those screened, 1,124 (31.3%) had a potential delay. Of the children screened, 1,453 (40.5%) required a Plan of Action for a Potential Delay or Parental Concern and 385 (26.5%) were referred for additional services including early intervention. Of those referred, 128 (33.3%) are receiving services.

2. Social-emotional screening of young children--Direct Health Care Services--Children, including CYSHCN

The State MCH Program continued to promote connected and comprehensive systems of early childhood for all children that included social-emotional developmental screening using a valid, reliable tool that supports both provider practice and parental knowledge. State public health programs report developmental screening results using the ASQ:SE tool in SPHERE and track outcomes of a plan for intervention if indicated. During 2011, 1,798 unduplicated social-emotional developmental screens were reported in SPHERE for children up to age 5 years. Of those screened, 126 (8%) had a potential social-emotional concern. Of the children screened, 259 (14.4%) required a Plan of Action for a Social-Emotional/Parental Concern and 76 (29.3%) were referred for additional services including early intervention. Of those referred, 24 (31.6%) are receiving services.

3. Education and training--Enabling Services--Children, including CYSHCN

Education and training to promote accurate use of ASQ and ASQ:SE for variety of public health

providers and while focusing on cross-training, workforce development continued in 2011 within MCH/CYSHCN programs and activities. The WI Statewide Medical Home Initiative (WISMHI) provided training to 89 primary care providers on the ASQ 3 and M-CHAT. Trainings were done in partnership with the Regional Center for CYSHCN and local Birth-3 (Part C) provider. The WI Statewide Medical Home Initiative (WISMHI) provided training to 89 primary care providers on the ASQ 3 and M-CHAT. Trainings were done in partnership with the Regional Center for CYSHCN and local Birth-3 (Part C) provider.

#### 4. Early Childhood Comprehensive Systems (ECCS) Plan--Infrastructure Building Services--Children, including CYSHCN

Since September 2006, Wisconsin Alliance for Infant Mental Health (WI-AIMH) has provided leadership for many ECCS activities. With support of Wisconsin ECCS grant dollars, there has been a collaborative focus to increase capacity to provide effective infant and young child mental health services and consultation. The Infant Mental Health Endorsement process was initiated in Summer 2011. In 2011, 27 persons enrolled in the UW Infant, Early Childhood and Family Mental Health Certificate Program-Foundations Certificate. They will be eligible to be endorsed to provide infant mental health services, a verifiable process that supports professional development across different disciplines and recognizes an individual's achievements in training, education, and experience. WI-AIMH continued to support the work of state and local organizations across a variety of providers in their screening programs for infants and young children.

#### 5. WI Healthiest Families Initiative (WHFI)--Population-Based Services--Infant and Children

The WHFI was implemented with LHDs to support a system of services related to child development as well as family supports, mental health, safety, and injury prevention. Expected outcomes related to child development include: 1) increased number of service providers using a valid developmental screening tool such as the ASQ with results communicated to the Medical Home, 2) adoption by community partners of AAP recommendations for developmental screening at 9, 18, and 30 months, and 3) increased number of completed referrals for follow-up services as indicated, including Early Intervention.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Developmental screening of young children	X			
2. Social-emotional screening of young children	X			
3. Education and training		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

##### 1. Developmental screening of young children--Direct Health Care--Children, including CYSHCN

The MCH Program and Project LAUNCH continue to promote early developmental screening across settings, including LHDs and the SPHERE data system is available for use by a variety of providers.

##### 2. Social-emotional screening of young children--Direct Health Care Services--Children, including

## CYSHCN

The Program continues to promote early social-emotional developmental screening across settings, including LHDs and the SPHERE data system is available for use by a variety of providers. LAUNCHs home visiting component regularly conducts social-emotional screens within the program.

### 3. Education and training--Enabling Services--Children, including CYSHCN

WISMHI continues to provide training to primary care practices throughout the state on the implementation of developmental screening. LAUNCH joined that collaboration to focus trainings within the City of Milwaukee. LAUNCH, with University of Wisconsin-Extension, trained childcare providers within the City of Milwaukee. LAUNCH has worked with community partners, including the 2-1-1 hotline to promote the importance of universal screening.

### 4. ECCS Plan--Infrastructure Building Services--Children, including CYSHCN

Education and promotion of screening continues through the ECCS grant and the Governor's Early Childhood and Advisory Council.

### 5. WHFI--Population-Based Services--Infant and Children

10 LHDs and tribal agencies are focusing on child development.

## **c. Plan for the Coming Year**

### 1. Developmental screening of young children--Direct Health Care--Children including CYSHCN

The MCH Program will continue to promote early developmental screening within state and local partnerships and programs, including LHDs, medical clinics, home visiting programs, at schools, and with child care providers. State funded home visiting programs will be required to implement developmental screening using a valid tool. The SPHERE data system is available for use by a variety of providers throughout WI and developmental screening data will be monitored and reported annually as available.

### 2. Social-emotional screening of young children--Direct Health Care Services--Children, including CYSHCN

The MCH Program will continue to promote early social-emotional developmental screening within state and local partnerships and programs, including LHDs, medical clinics, home visiting programs, at schools, and with child care providers. The SPHERE data system is available for use by a variety of providers throughout WI and social-emotional developmental screening data will be monitored and reported annually as available.

### 3. Education and training--Enabling Services--Children, including CYSHCN

WISMHI will continue to train medical providers throughout the state on the implementation of developmental screening. Based on a 2012 pilot with the Marshfield clinic, it is anticipated the approach will focus on health care system or network level training versus the individual practice level. Project LAUNCH will continue to focus on providing trainings and technical assistance within the City of Milwaukee. LAUNCH, in collaboration with University of Wisconsin-Extension, will continue to provide training and technical assistance to childcare providers within the City of Milwaukee. LAUNCH will continue to work with community partners, including the 2-1-1 hotline to promote the importance of universal screening and LAUNCH plans to reach out to other hotlines to promote collaboration around developmental screening and improving community and family awareness of available resources.

#### 4. ECCS Plan--Infrastructure Building Services--Children, including CYSHCN

The State MCH Program, in collaboration with numerous state and local partners, will participate on the Governor's Early Childhood Advisory Council and related subcommittees. The council has a broad focus and one of the proposed subcommittees will focus on screening and assessment.

#### 5. WHFI--Population-Based Services--Infant and Children

LHDs will continue to use MCH funds for the WHFI. A Learning Community will be convened of LHDs implementing systems approaches to support child development. Education will be provided using a Developmental Screening Toolkit developed by the WI Early Childhood Collaborating Partners. TA will continue to be provided by the MCH Program and UW Extension to support LHDs as they progress through steps of assessment, planning, implementation/evaluation and sustainability/quality improvement.

### **State Performance Measure 7:** *Percent of children under 1 year of age enrolled in Wisconsin's Birth to 3 Program during the calendar year.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					1.1
Annual Indicator				1.0	0.9
Numerator				716	655
Denominator				73086	69446
Data Source				WI DHS, IFPS.	WI DHS IFPS, 2011.
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	1	1	1	1	1

#### **Notes - 2011**

Data Source: Numerator. Wisconsin Program Participation System (PPS) U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS), "Report of infants and toddlers receiving early intervention services in accordance with Part C," 2010. <https://www.ideadata.org/PartCData.asp> WI DHS, Birth to 3 program, 2012. Denominator: Wisconsin Department of Health Services, Office of Health Informatics, US Census, 2010. Our objectives are: .96% - 2012, .97% - 2013, .98% - 2014, .99% - 2015, 1.0% - 2016. The TVIS does not accept objectives less than 1.0%.

#### **Notes - 2010**

Source: WI DHS, Birth to 3 program, 2010. Data issue: the indicator is .0098 (the TVIS would not calculate this). We are projecting our objectives based on program information from Wisconsin's Birth to 3 program and will modify them as necessary to correspond to the Office of Special Education Programs targets.

#### **Notes - 2009**

Data are not available.

#### **a. Last Year's Accomplishments**

1. MCH Early Childhood Systems--Infrastructure Building Services--Infants and Young Children including CYSHCN

In 2011, MCH dollars to LHDs began supporting early child systems approaches to address priorities identified by the 2010 MCH needs assessment. Two initiatives were implemented as a pilot under this work to develop the components of Keeping Kids Alive{KKA} (development of local CDR and FIMR teams and moving their recommendations to prevention) and WI Healthiest Families {WHFI} (focusing on family supports, child development, injury prevention and safety, and mental health). Fifty one LPHDs chose this objective in 2011 and began assessments of the system of services within their jurisdictions.

## 2. Healthy Children's Committee of Early Childhood Comprehensive Systems--Infrastructure Building Services--Children, including CYSHCN.

The Committee drafted a "Blueprint for a Comprehensive and Aligned system for Screening and Assessment of Young Children" available at: ([www.dcf.wisconsin.gov/ecac/pdf/22112\\_blueprint.pdf](http://www.dcf.wisconsin.gov/ecac/pdf/22112_blueprint.pdf)). Recommended periodicity is based on Bright Futures and WI Model Early Learning Standards Domains.

## 3. Screening within Medical Home Hub of Excellence--Infrastructure Building Services--Children, including CYSHCN

Beginning in January 2011 the CYSHCN Program funded the NE Regional Center to lead the CYSHCN Program's Wisconsin Statewide Medical Home Initiative (WisMHI) in partnership with CYSHCN collaborators including Birth-3 (Part C). WisMHI staff conducted a webinar for all local Birth-3 providers on the Initiative and its work to promote screening and referral. In 2011, 75 providers (28 practices) received training on early identification and referral with county Birth-3 and Regional Center staff. By the end of 2011 training had occurred in 36 of WI's 72 counties.

In addition, WisMHI partnered with the Learn the Signs Act Early (LTSAE) Ambassador and Connections grant staff. Wisconsin-specific Milestone Moments booklets were made available to pediatricians and family physicians, Regional Centers, public health departments, Children's Long-Term Support professionals, WIC professionals, and others working with families of young children. The redesigned Screening/Early Identification website of Wisconsin Early Childhood Collaborating Partners links extensively to the Wisconsin Act Early site ([www.actearly.wisc.edu/](http://www.actearly.wisc.edu/)). The new site's "Parent Resources" page ([www.waisman.wisc.edu/cedd/collaboratingpartners/familyresources.php](http://www.waisman.wisc.edu/cedd/collaboratingpartners/familyresources.php)) features and promotes the information on the Wisconsin Act Early site, and links directly to it in many areas. A Learn the Signs Act Early grant submitted by the Waisman Center in partnership with the MCH Program was funded in late 2011 to disseminate Milestone Moments information to home visiting (including MIECHV, Family Foundations) and PNCC programs to distribute resources to their families.

## 4. Wisconsin Medical Home Autism Spectrum Disorder (ASD) Connections Initiative--Infrastructure Building Services--Children, including CYSHCN

The CYSHCN Program was in the final year of a 3 year federal grant, as part of the Combating Autism Act Initiative, to strengthen the state's infrastructure to improve services for children with ASD and other developmental disabilities. Connections resulted in the following outcomes: 1) the implementation of medical home quality improvements to increase appropriate developmental screening, identification and referrals including the creation of a WI Medical Home webcast series ([www.waisman.wisc.edu/connections/webcast.php](http://www.waisman.wisc.edu/connections/webcast.php)); 2) the addition of over 500 resources to the First Step data base (WI Birth to Three in collaboration with the MCH Program's toll free system for referral information) through resource mapping; and 3) the infrastructure building of the CYSHCN Regional Centers to enhance their ability to provide information, referrals, technical assistance and training in each region. Region specific fact sheets were developed in partnership with the Autism Society of WI to promote early identification and resource linkages including information on Birth-3. During the last year of the grant, the CYSHCN Program and its Steering

Committee partners created a sustainability plan that included promotion of developmental screening including ASD among primary care providers as part of the Medical Home hub.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH Early Childhood Systems				X
2. Healthy Children's Committee of Early Childhood Comprehensive Systems				X
3. Screening within Medical Home Hub of Excellence				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

1. MCH Early Childhood Systems--Infrastructure Building Services--Infants and Young Children including CYSHCN

18 LHDs and Great Lakes Inter-Tribal Council are specifically addressing the child development focus area of the WI Healthiest Families Initiative, working to develop local early childhood systems to support achieving a statewide structure of early screening, identification and referral to Birth-3 programs for intervention services.

2. Healthy Children's Committee of Early Childhood Comprehensive Systems--Infrastructure Building Services--Children, including CYSHCN

The Healthy Children's Committee's Blueprint is included in the Governor's State Advisory Council on Early Childhood Education and Care report available at (<http://dcf.wi.gov/ecac/pdf/report.pdf>). The Governor's report calls for an increase and coordination of screening and assessment.

3. Screening within Medical Home Hub of Excellence--Infrastructure Building Services--Children, including CYSHCN

The hub is collaborating with the B-3 Child Find Committee on drafting a standardized referral and communication form based on the Oregon Start Program. WisMHI is working with Project LAUNCH in Milwaukee to promote early identification and referral to Birth-3. WisMHI is working with WAFP and WIAAP to administer a survey to determine providers developmental screening and referral practices which will be a repeat of a statewide survey conducted in 2007.

**c. Plan for the Coming Year**

1. MCH Early Childhood Systems--Infrastructure Building Services--Infants and Young Children including CYSHCN

LHDs and tribal agencies will continue to receive MCH block grant funds to support early childhood systems. This is multi-year work with agencies progressing through steps of assessment, planning, implementation/evaluation and sustainability/quality improvement. The Life Course Framework and core competencies based on the MCH Leadership competencies will continue to provide the foundation for this work. It is anticipated that over the course of five years,

there will be improved and more comprehensive local systems of early childhood services for all children in Wisconsin. These connections should enhance a statewide structure to support early screening, identification and referral to the Birth to Three programs for necessary intervention services.

## 2. Healthy Children's Committee of Early Childhood Comprehensive Systems--Infrastructure Building Services--Children, including CYSHCN

The Healthy Children's Committee will work in partnership with the Governor's ECAC to implement the recommendations of the Blueprint.

## 3. Screening within Medical Home Hub of Excellence--Infrastructure Building Services--Children, including CYSHCN

The CYSHCN Program and hub will continue to promote developmental screening with standardized tools and early referral to Birth-3 among health care providers. Outreach efforts will focus on health system training (versus individual practice sites) tested. In this model the health system network agrees to provide a "trainer(s)" who will have responsibility to train other clinics within the system and new providers as they enter the network. This model is being tested in 2012 with the Marshfield Clinic system and other large health systems that have expressed interest in participating. All outreach and training will include promotion of the First Step hotline and referral website, Regional Centers, and Birth-3. The hub will promote the Birth-3 Program's common referral form when approved.

## 4. Wisconsin Sound Beginnings (WSB)--Infrastructure Building Services--Children, including CYSHCN

WSB's WE-TRAC data system will continue to make direct referrals to the Birth-3 program for those infants diagnosed as deaf or hard of hearing to facilitate early enrollment in Birth-3.

## **E. Health Status Indicators**

### Introduction

2011 data are required by the TVIS for the Health Status Indicator (HSIs), forms 20 and 21 for the 2013 Title V Block Grant Application; however, for the majority of these indicators (with the exception of program data for chlamydia [#05A and #05B], 2011 data are not available. Therefore, we used the most recent data available (in most cases, 2010 data) as estimates for 2011 and so indicated in a data note.

We classify the HSIs into 4 groups:

1. Birth outcomes, low birth weight: 01A-02B;
2. Injury (fatal and nonfatal) outcomes by age for children and youth/young adults: 03A-04C;
3. Women's health; reported cases of chlamydia by age: 05A-05B; and,
4. Population-based demographics: number of children, births and deaths, and descriptive program indicators by age and race/ethnicity; and descriptive census indicators for percent of population by geographic living area and federal poverty level (FPL):6A-10.

The first two groups are high priority for our programs. The data from these HSIs are used as baseline data and regularly analyzed for ongoing program evaluation. These HSIs are also used to assist our Needs Assessment (Section II.) and identification of our priorities for Title V. Attachment II.C - Healthy People at Every Stage of Life: Maternal and Child Health Federally Reported Indicators and Progress shows how the HSCIs align with the BCHP's Healthy People at Every Stage of Life.

The other two groups, which include women's health indicators and descriptive demographic indicators, are used to inform staff about Wisconsin's citizens. Generally, they are not used to monitor programs or provide information for evaluation.

Health Status Indicators 01A: The percent of live births weighing less than 2,500 grams,  
Health Status Indicators 01B: The percent of live singleton births weighing less than 2,500 grams,  
Health Status Indicators 02A: The percent of live births weighing less than 1,500 grams, and  
Health Status Indicators 02B: The percent of live singleton births weighing less than 1,500 grams.

The Wisconsin Births and Infant Deaths Report 2010, identifies the disparity between the Black/African American and white infant low birthweight rates. This disparity is even greater for the very low birthweight (less than 1,500 grams or 3.3 pounds at birth). In 2008-2010, Black/African American infants were 2.9 times as likely to be born at very low birthweight as were white infants. Higher percentages of low birthweight infants were born to: mothers who received no prenatal care (22.4%), non-Hispanic Black African/American women (13.8%), and women who smoked during pregnancy (13.8%). Twins and other multiples made up 25.6% of all low birthweight births.

DPH and Medicaid are monitoring and tracking a department priority initiative, "Reduce preterm, low birth weight and infant mortality rates for BadgerCare Plus HMO members in Southeastern Wisconsin". This initiative includes improving breastfeeding rates; identifying new communities for fetal and infant mortality and child death reviews; poor birth outcome assessments for BadgerCare Plus members; preterm labor prevention, including the use of 17P; and the web-based registry for high risk pregnant women.

This accountability initiative combines a number of current efforts to improve birth outcomes and reduce infant mortality into a more coordinated approach and includes an enhanced focus on monitoring and using data to drive decisions. The initiative includes the following 5 objectives:

1. Design and implement a web-based data system to improve access to the high-risk registry, improve data management, and identify trends in care delivery.
2. Increase the proportion of fetal and infant deaths (< age1) that are reviewed by local or regional teams using a standardized process, including the collection of uniform data elements.
3. Medicaid Medical Home and Pay for Performance (P4P):
  - a) Explore the feasibility of expanding the Medical Home Pilot to other high-risk populations and/or counties.
  - b) Begin chart reviews for the Poor Birth Outcome Assessment.
  - c) Identify metrics for P4P measure and develop baselines.
4. Examine breast feeding initiation and duration rates for women receiving peer counseling services compared to women without peer counseling.
5. Define and identify women with a previous preterm birth who should be given 17-P to develop a baseline.

Another effort, the Wisconsin Healthiest Women Initiative (WHWI) strives to improve the health of women and improve birth outcomes.

The MCH Program received Technical Assistance from Alvina Long Valentin of North Carolina in 2011 for the WHWI. A Leadership Workgroup consisting of 14 representatives from statewide women's health organizations guided the Initiative. Forums were held with 60-80 people participating in discussions about the current health of women in WI and what is needed to achieve the 3 goals of: 1) Build and strengthen community capacity, 2) Expand access to affordable and high quality services, and 3) Improving accountability: Identifying and monitoring relevant information. With WI PRAMS and BRFSS data, participants selected the 2 focus areas of Socioeconomic & Environmental Determinants of Health and Sexual Health & Pregnancy Planning. Workgroups were formed to identify system level strategies for moving the Initiative to the community level. WHWI will launch a website, Every Woman WI, to distribute WI's Statewide

Framework for Improving Women's Health and to serve as a resource to providers, consumers, and health systems.

MCH will also continue to work with 2 statewide partners, Wisconsin Association for Perinatal Care (WAPC) and Health Care Education and Training (HCET) to implement preconception pilot projects in clinics and health systems. WAPC is working with a Milwaukee women's clinic and 2 health plans to integrate their preconception tools into existing practices. WAPC promotes use of their tool "Prescription for a Healthy Future, developed a tool to address postpartum weight management, and is working to integrate their preconception algorithm into the electronic health record. See ([www.perinatalweb.org](http://www.perinatalweb.org)). HCET is working with 4 women's health clinics to implement interconception services focusing on family planning, depression screening, physical activity, and tobacco use. Both agencies will share the process and results at statewide public and clinical health conferences. MCH will continue to search for opportunities to integrate the WHWI Framework into other division programs.

Key indicators of women's health are being measured for objectives in the State Health Plan, Healthiest Wisconsin 2020. In addition, the MCH Program will explore a fetal and infant mortality data analysis using the Perinatal Periods of Risk model that assesses fetal and infant deaths based on birth weight and age at time of death. The last PPOR analysis in WI was completed with 2002-2004 fetal and infant mortality data. Maternal Health/Prematurity issues relate to birthweights less than 1500 grams.

Health Status Indicators 03A: The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger;

Health Status Indicators 03B: The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes;

Health Status Indicators 03C: The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years;

Health Status Indicators 04A: The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger;

Health Status Indicators 04B: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger; and

Health Status Indicators 04C: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

Wisconsin has seen improvements in injury rates for children over the past several years thanks to changes in policy, environment and behavior, primary seat belt law, booster seat law; however, injuries remain the leading cause of death for children. MCH remains committed to improving these numbers as evident in the needs assessment and MCH priority and HW 2020 for safe and healthy communities. Strategic planning following the needs assessment lead to the development and implementation of the Keeping Kids Alive (KKA) Initiative to establish a sustainable, coordinated system to identify causes of all fetal, infant and child deaths, resulting in preventive strategies for community action. In 2012 30 LHDs are using MCH funding for implementation of KKA. Through ongoing child death reviews (CDR) at the local level, multiple injury issues have been brought to light and prevention initiatives developed and expanded across the state, such as infant safe sleep. Thanks to CDR and the emphasis on systems building, consistent messaging and organizational policies that support safe sleep, e.g., within hospitals, childcare centers, home visiting programs, are being implemented across the state. Children's Health Alliance of Wisconsin continues to provide statewide technical assistance and training to LHDs on the KKA Initiative. CHAW works collaboratively with the City of Milwaukee to reduce sleep related infant deaths by encouraging health systems to adopt policy language on modeling safe sleep to families and implementing uniform safe sleep messaging. Additionally, CHAW received a UW Partnership grant in collaboration with the City of Milwaukee Health Department, the Injury Research Center at the Medical College of Wisconsin, and the MCH Program to expand FIMR across the 4 WI counties (Milwaukee, Kenosha, Racine, and Rock) with significant disparities in poor birth outcomes and to develop a data base to support a statewide FIMR. By continuing to

focus efforts on CDR and systems change the MCH and Injury and Violence Prevention Programs expect to see a greater decrease in a variety of childhood injuries over the next several years.

Health Status Indicators 05A: The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia, and

Health Status Indicators 05B: The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

The rates of women reported with chlamydia are based upon the number of cases of chlamydia reported to the Wisconsin STD morbidity database (WEDSS). Among 15-44 year old women, the rates have steadily increased per 1,000 women over the past three years, despite fluctuations in population estimates for this age group.

The positivity rate is based upon the number of positives identified of specimens tested in this age group at the SLH. These rates have also steadily increased over this same time period, despite fluctuation in the volume of testing. In the 15-19 age group, women testing as positive at the SLH represent approximately one quarter of the women reported statewide with chlamydia. In the 20-44 age group, women testing as positive at the SLH represent approximately one fifth of the women reported statewide with chlamydia.

Of all positive specimens reported by the SLH in 2011 for women ages 15-44 years of age, 83% came from women at family planning clinics who were selectively screened for chlamydia to identify patients at the highest risk of infection, using established evidence based risk criteria (3,354 positives for chlamydia identified at FP clinics of 4,042 positive chlamydia cases identified at the SLH in 2011 in the 15-44 year age group).

The Wisconsin MCH Women's Health-Family Planning/Reproductive Health Program has established a standard of care and quality indicators for Chlamydia prevention and control, and performance measurement requirements and benchmarks for increased accountability. Practice requirements address patient education, screening, testing, treatment, and re-testing. These have been established as essential components of community-based family planning/reproductive care accompanying contraceptive services. The goals are to increase patient awareness of personal STD exposure risk, and to motivate and support patients to adopt behaviors to reduce the risk of STD exposure. Epidemiologic-based screening criteria have been established to identify patients at a higher relative risk of infection and a priority for testing. Dual Protection, another priority standard of care, is integrated with STD services. It is the primary prevention goal toward maintaining reproductive health and protecting fertility.

Health Status Indicators 06A: Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)

Of the 1,888,748 Wisconsin residents under 25 years of age, 79% are white, 8.2% are African American, 9.3% are Hispanic/Latino, 1.2% are American Indian, 3.2% are Asian, .04% are Native Hawaiian, and 3.7% are multiracial. The fastest growing ethnic group in Wisconsin is Hispanic/Latino. Although about 9% of the total population under 25 is Hispanic/Latino, 9.5% of infants less than one year of age are in this age group.

Health Status Indicators 06B: Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)

HSI #06B - Demographics (TOTAL POPULATION)

Ninety percent (1,711,430) of Wisconsin residents under 25 years of age are not Hispanic or Latino.

Health Status Indicators 07A: Live births to women (of all ages) enumerated by maternal age and

race. (Demographics)

In Wisconsin, in 2010, there were 68,367 live births that occurred to Wisconsin residents (2,457 fewer than in 2009) (Wisconsin Department of Health Service, Division of Public Health, Office of Health Informatics. Wisconsin Births and Infant Deaths, 2010 (P-45364-10). January 2012). Overall, 83.6% of births were to white infants, followed by 10.2% of black infants, 2.8% of Asian infants, 1.8% of American Indian infants, and 1.4% of Native Hawaiian (.1% were of other/unknown race). Seven percent of infants were born to women under 20 years of age, 79.6% to women 20-34 years of age, and 12.8% to women 35 and older. By race/ethnicity, African American teens had the highest percentage of births at 20%, followed by American Indians at 16%, 13% for Hispanic/Latina, 12% for Laotian or Hmong, 5% for white, and 3% for other Asian.

Health Status Indicators 07B: Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)

Of the 68,367 live births to Wisconsin residents in 2010, 90.3% (61,803) were not Hispanic/Latina infants and 9.5% were Hispanic/Latina. 86.8% of non-Hispanic births were to women 20-34 years of age, and 13.1% to women under the age of 20.

Health Status Indicators 08A: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)

In 2010, 962 children and young adults died in Wisconsin: these deaths represented 2% of all deaths in Wisconsin. 37.7% were under one year of age, 5.6% were 1-4, 4.5% were 5-9, 4.9% were 10-14, 18.5% were 15-19, and 28.7% were 20-24. Of the 393 infant deaths in 2010, 247 (62.8%) were white infants and 24.2% (95) were black infants; however, the infant mortality rate per thousand live births to white infants was 4.9 compared to 13.9 for black infants.

Health Status Indicators 08B: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)

Eighty Hispanic/Latino children died during 2010, representing 7.6% of the total deaths; 43.8% (35) of them were to infants.

Infant mortality and birth outcomes in 2010 continue to show stable or slightly downward trends among all racial and ethnic groups. DHS has created a priority initiative to track progress in the Medicaid medical home pilot and pay-for-performance measures for birth outcomes, the use of 17-P, FIMR, PNCC, and breastfeeding. The Statewide Advisory Committee will continue to plan jointly with the Wisconsin Healthiest Women Initiative. The Milwaukee Journal Sentinel is continuing its 2011 series on infant mortality during 2012. The City of Milwaukee Health Department will host a 3rd Infant Mortality Summit in June. The Mayor and Health Commissioner announced the 2017 goal of reducing all infant mortality by 10% and African American infant mortality by 15%. The Wisconsin Partnership Program has funded Community Action Plans to improve birth outcomes and reduce disparities among African American births in Milwaukee, Racine, Kenosha, and Beloit and the LIHF Collaboratives and local implementation projects will be funded in 2012.

Health Status Indicators 09A: Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)

There are limitations to these indicators: they are not consistently reported by age and race/ethnicity across state and federal agencies; they are not defined consistently (number, rates, percentages) and methodologies for their collection and reporting change from year-to-year and by agency. Also, it is difficult to compare these indicators because annual reports are not published for all of them on a consistent basis. About 26% of Wisconsin's population is children,

0-19. Overall, Wisconsin's children do well: they have a relatively low high school drop out rate, low rate of juvenile arrest, and enrollment numbers for Medicaid/BadgerCare have increased. However, when examined by race/ethnicity, there are outstanding disparities; for example, proportionately, there are more black children enrolled in foster care homes, the food stamp program, Medicaid/SCHIP and WIC. Minority children have higher rates of juvenile violent crime and high school drops. Section III, State Overview, of the 2013 MCH Title V Block Grant Application describes other significant disparities for Wisconsin's children.

Health Status Indicators 09B: Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity.  
(Demographics)

There are limitations to these indicators: they are not consistently reported by age and race/ethnicity across state and federal agencies; they are not defined consistently (number, rates, percentages) and methodologies for their collection and reporting change from year-to-year and by agency. Also, it is difficult to compare these indicators because annual reports are not published for all of them on a consistent basis. About 26% of Wisconsin's population is children, 0-19; about 10% of them are Hispanic or Latino. Overall, Wisconsin's children do well: they have a relatively low high school drop out rate, low rate of juvenile arrest, and enrollment numbers for Medicaid/BadgerCare have increased. However, when examined by race/ethnicity, there are outstanding disparities; for example, proportionately, there are more black children enrolled in foster care homes, the food stamp program, Medicaid/SCHIP and WIC. Minority children have higher rates of juvenile violent crime and high school drops. Section III, State Overview, of the 2013 MCH Title V Block Grant Application describes other significant disparities for Wisconsin's children.

Health Status Indicators 10: Geographic living area for all children aged 0 through 19 years.

In 2010, 1,502,196 children under the age of 20 lived in Wisconsin; they represented about 26% of the states' population. 74% lived in urban areas, and 26% lived in rural areas.

Health Status Indicators 11: Percent of the State population at various levels of the federal poverty level.

In 2010, approximately 5.7 million people lived in Wisconsin. About 319,200 (5.6%) subsisted at less than 50% of the federal poverty level, more than 750,000 (13.5%) at 100% FPL, and more than 2 million (36.1%) at 200% FPL.

Health Status Indicators 12: Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.

In 2010, about 1.5 million children under the age of 20 lived in Wisconsin; about 84,000 (5.6%) lived at less than 50% of the federal poverty level, more than 200,000 (13.5%) at 100% FPL, and more than half a million (36.1%) at 200% FPL.

## **F. Other Program Activities**

### **TEXT4BABY**

The WI DPH is an outreach partner to assist in the promotion of text4baby. A website is available to promote the campaign to our partners at ([http://dhs.wisconsin.gov/dph\\_bfch/MCH/text4baby.htm](http://dhs.wisconsin.gov/dph_bfch/MCH/text4baby.htm)). This information has been distributed broadly to MCH local and statewide partners across the state.

/2012/ Continue to promote text4baby across the state. Presented to the Medicaid HMO Contract Administrators, which includes 18 health plans from across the state. //2012//

***/2013/ MCH Hotline has built text4baby into its referral process. Enrollment data by zip code is being analyzed, allowing us to look at hotline and agency referrals to see if women are actually enrolling. //2013//***

## MCH HOTLINE

Gundersen Lutheran Medical Center-LaCrosse provides services for the Public Health Information and Referral Services for Women, Children and Families (hotline) contract. The contract supports multi-program funded services for 3 hotlines that address a variety of MCH issues to include: Prenatal Care Coordination (PNCC), WIC, family planning, women's health, and CYSHCN. Wisconsin First Step (WFS) is specifically dedicated to supporting the needs of the Birth to 3 Program, the CYSHCN Regional Centers, and providing information and referral services to individuals, families, or professionals needing to find resources for CYSHCN. In 2009, the MCH Hotline received 7,997 calls, with 3% of the calls requiring Spanish translation, and WFS received 1,810 calls. In addition to the toll-free hotlines, the web site ([www.mch-hotlines.org](http://www.mch-hotlines.org)) has become a well-utilized resource with approximately 89,500 hits in 2009. Five regional WFS directories are available on the website. A searchable database feature was added to the website in 2003 with a new software program, ReferNet, added in early 2010. This software upgrade will enhance in-house searching capabilities as well as the public web search engine.

/2012/ In 2010, MCH Hotline received 7,565 calls, with 3% requiring Spanish translation, and WFS received 1,820 calls. For the website, over 75,000 pages of the online database were viewed in 2010. //2012//

***/2013/ In 2011, MCH Hotline received 6,701 calls, with 2% requiring Spanish translation, and WFS received 1,686 calls. Data continues to support the website and online database are a well utilized resource. In collaboration with hotline staff, we will be in contact with Region V partners and state and local partners to assist us in gathering information about why call volume continues to decrease. Conversations are underway regarding connecting LHD early childhood systems resources to the hotline. Hotline staff will attend a Family Health Section staff meeting to discuss services and supports. The MCH Program is looking at a model for how 2-1-1 in Milwaukee has provided information and referral support to Project LAUNCH to see if it can be replicated statewide. //2013//***

## NUTRITION PARTNERSHIPS

WIC Nourishing Special Needs is a collaborative project with WIC, CYSHCN, and Birth Defects Prevention Programs. The Birth Defects Nutrition Consultant Network (BDNCN) provides nutrition-related education and support to WIC clients and providers at 17 LHDs across the state. A 2008 evaluation of the BDNCN documented the following: 1) WIC registered dietitians were frequently the first to identify the need for assessment, diagnosis and referral for suspected health care problems related to birth defects resulting in a 3-fold increase in referral of children with birth defects to the WI CYSHCN Regional Centers; 2) improved communication and collaboration with other local agencies, medical providers/tertiary centers; 3) improved integration of nutritional care with early intervention programs including B-3 and Head Start. The BDNCN has presented these results at national (Birth Defect Prevention Network, WIC Assoc) and state (Public Health Assoc, Dietetic Assoc) conferences. This Program currently serves about 15% of WIC clients.

The WI Partnership for Activity and Nutrition (WI PAN) requested a legislative council study on childhood obesity with BCHP and many others providing testimony. The committee recommendations include: 1) inclusion of a wellness component in a child care quality rating system, 2) school nutrition standards for foods and beverages available on the school campus, 3) annual physical fitness assessment (FitnessGram) for grades 3-12, and 4) built environments. These served as a framework for WI to successfully compete for the American Reinvestment and Recovery Act funds, Component II, to develop strategies that increase physical activities in

schools ([www.legis.state.wi.us/lc/committees/study/2008/LPOP/index.htm](http://www.legis.state.wi.us/lc/committees/study/2008/LPOP/index.htm)).

In addition, WI PAN in collaboration with CYSHCN and many state and childcare organizations is developing the WI Early Childhood Obesity Prevention Initiative to improve nutrition, increase physical activity and decrease obesity among 2-5 year old children in WI. The collaborative, statewide, multi-strategy, evidence-based plan will engage providers, families, community partners, and other stakeholders.

/2012/ Mentorship for the Nourishing Special Needs project was started in which 9 seasoned WIC nutritionists working with CYSHCN for multiple years were matched with 9 new WIC nutritionists. The WI WIC computer program ROSIE was modified to allow better documentation of clients with birth defects and referrals and retrieval of data. Of the total of 72 WIC projects in WI, 16 projects made 48% of the WIC referrals to the WI Birth to Three Program.

The WI Early Childhood Obesity Prevention Initiative (WECOPI) has expanded with the "What Works in Early Care and Education" including children with disabilities as part of a series of evidence based and promising strategies that focus on helping people eat healthier and be more active ([www.dhs.wisconsin.gov/publications/P0/P00232.pdf](http://www.dhs.wisconsin.gov/publications/P0/P00232.pdf)). //2012//

***/2013/ Additional resources for What Works for Early Care and Education have been added to the series including Active Early, Healthy Bites and a Self-Assessment Checklist for Childcare Provider (<http://www.dhs.wisconsin.gov/health/PhysicalActivity/index.htm>). See NPM 5 for update on Nourishing Special Needs. //2013//***

#### OTHER HEALTH PARTNERSHIPS

The WI Perinatal Depression Task Force lead by MCH and BMHSAS is a collaborative partnership of public health, clinical practitioners, academic partners, and community members. This task force has identified increasing the routine screening of all women for depression during the perinatal period through public health programs and clinical services as a primary focus. In 2009 29% of women receiving services through MCH programs were screened for depression; of those identified as at risk for depression 70% were referred for treatment and services per WI SPHERE. The 2007-2008 WI PRAMS data illustrates that 14% of women report symptoms of depression during the postpartum period.

Of the pregnant and postpartum women served through the WI MCH programs in 2009, 29% reported using alcohol prior to identification of pregnancy or during the postpartum period per SPHERE. The WI Women's Health Foundation's, My Baby and Me Program has been implemented at 9 pilot sites through the PNCC program. With frequent supportive contacts and incentives this strength-based service has shown a 70% reduction in alcohol use during pregnancy. Project expansion is planned.

/2012/ In 2010, 41% of the pregnant and postpartum women served through the WI MCH programs reported using alcohol prior to identification of pregnancy or during the postpartum period per SPHERE. See SPM #3 for information on perinatal depression. //2012//

***/2013/ In 2011 30% of the pregnant/postpartum women served through MCH programs and Medicaid PNCC reported using alcohol prior to pregnancy or during the postpartum period per SPHERE. PNCC providers are being offered training in screening, brief intervention, and referral to treatment (SBIRT). //2013//***

#### G. Technical Assistance

Wisconsin is interested in pulling together and having facilitated meetings with a high level group e.g. Michael Kogan, Laura Cavanaugh, and other national leaders, as well as our leading MCH and CYSHCN experts and thinkers e.g. Angie Rohan and MCH/CYSHCN epidemiologists, Dr.

Fleischfresser, Dr. Katcher, Title V Director Linda Hale, MCH Supervisor Terry Kruse, and SSDI Coordinator Loraine Lucinski to brainstorm helping to identify indicators and other evaluation methods the MCH Program can use that will allow the Program to move away from counting individuals to systems outcomes.

Wisconsin is interested in developing a state plan for preconception health. Initial activities will include identifying activities supporting preconception health that have been integrated into existing programs. Potential consultants to assist with the development and implementation of a state plan include Kay Johnson, MPH, Ed.M. with Johnson Group Consulting, Inc. or Alvina Long Valentin, RN, MPH with the North Carolina Division of Public Health.

/2012/ Wisconsin is still interested in identifying ways to measure successful systems development and outcomes as described above.

Secondly the WI MCH Program is interested in exploring the ability to further enhance SPHERE as a documentation as well as a data collection system. Based on the MCH priorities work we are doing with our local, regional and statewide partners, we have the need to reduce duplicative data entry whether it be for surveillance, analyses, or documentation. We need to be able to include information that will assist us in the measurement of not only individual outcomes but system outcomes. Thus we would like to work collaboratively with experts in the field of documentation and evaluation as well as those familiar with individual outcomes and systems work.

Wisconsin is in the process of developing a state plan for preconception health. Alvina Long Valentin is providing technical assistance. The Wisconsin Healthiest Women's Initiative has developed a Leadership Workgroup of MCH staff and external partners working in women's health. With Ms. Long's expertise the Leadership Workgroup identified the 3 primary goals and direction for the strategic planning process. The decision to utilize the existing Framework for Action to Eliminate Racial and Ethnic Disparities in Birth Outcomes as the framework to build this initiative was agreed upon. The Leadership Workgroup identified partners for and planned the first forum held in June 2011, where we presented some of what has already been done in Wisconsin in preconception health and the current state of the health of Wisconsin women of childbearing age. Small group discussion was held in World Café style around the 3 primary goals of: 1) Build and Strengthen Community Capacity, 2) Expand Access to and Availability of High-Quality Services, and 3) Improve Accountability-Identify and Monitor Relevant Information. The Leadership Workgroup will follow up with a summary of the discussion and begin planning for the next forum in September 2011. This next forum will be joined with the Statewide Advisory Committee on the elimination of racial and ethnic disparities in birth outcomes. //2012//

***/2013/ Wisconsin will be requesting assistance in evaluating the systems changes and improvement in local communities from the move from individual services to delivery of services through a community systems approach. We would like to develop an evaluation plan that will include identified benchmarks demonstrating the impact of local MCH efforts on the service delivery systems. We would also like to develop an evaluation plan for the assessment, planning, implementation, evaluation, and sustainability steps for the early childhood systems objectives for local health departments and communities funded by MCH block grant funding. The MCH delivery system in the service area of each LHD would be assessed for 1) existence, coverage, and quality of local MCH efforts, 2) system coordination, and 3) partner collaboration. And last but not least, we would like to identify a means to quantify the reach of local systems activities for reporting in the Title V MCH Block grant report and application. //2013//***

## V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

### Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>1. Federal Allocation</b> (Line1, Form 2)	10732515	10646989	10637979		10658234	
<b>2. Unobligated Balance</b> (Line2, Form 2)	0	0	0		0	
<b>3. State Funds</b> (Line3, Form 2)	9395268	9912967	8741883		9657814	
<b>4. Local MCH Funds</b> (Line4, Form 2)	0	0	0		0	
<b>5. Other Funds</b> (Line5, Form 2)	0	0	0		0	
<b>6. Program Income</b> (Line6, Form 2)	7669622	9375410	7904939		9375410	
<b>7. Subtotal</b>	27797405	29935366	27284801		29691458	
<b>8. Other Federal Funds</b> (Line10, Form 2)	150170499	150170499	148760857		149496219	
<b>9. Total</b> (Line11, Form 2)	177967904	180105865	176045658		179187677	

### Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>I. Federal-State MCH Block Grant Partnership</b>						
<b>a. Pregnant Women</b>	3084269	2071293	2053626		2312660	
<b>b. Infants &lt; 1 year old</b>	2107339	2627321	2166123		2645755	
<b>c. Children 1 to</b>	8713743	10106786	8698689		9687243	

<b>22 years old</b>						
<b>d. Children with Special Healthcare Needs</b>	7073146	6535356	4423968		4221198	
<b>e. Others</b>	6150537	7972135	9247716		10154443	
<b>f. Administration</b>	668371	622475	694679		670159	
<b>g. SUBTOTAL</b>	27797405	29935366	27284801		29691458	
<b>II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).</b>						
<b>a. SPRANS</b>	0		0		0	
<b>b. SSDI</b>	100000		100000		100000	
<b>c. CISS</b>	0		0		0	
<b>d. Abstinence Education</b>	0		0		0	
<b>e. Healthy Start</b>	0		0		0	
<b>f. EMSC</b>	130000		130000		130000	
<b>g. WIC</b>	91296219		87001383		92904499	
<b>h. AIDS</b>	1577285		2913826		2574454	
<b>i. CDC</b>	53888245		54263978		50947686	
<b>j. Education</b>	0		0		0	
<b>k. Home Visiting</b>	0		0		945567	
<b>k. Other</b>						
<b>Lead, Tobacco, ECCS</b>	0		0		1044013	
<b>Project Launch(SAMSA</b>	0		0		850000	
<b>See Budget Narr B.</b>	0		4351670		0	
<b>Eight additional</b>	3178750		0		0	
<b>programs</b>	0		0		0	

### Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>I. Direct Health Care Services</b>	14284868	16240698	11697028		13266344	
<b>II. Enabling Services</b>	3378331	3701343	3346039		3637451	
<b>III. Population-Based Services</b>	1313951	1253921	3841718		3897147	
<b>IV. Infrastructure Building Services</b>	8820255	8739404	8400016		8890516	
<b>V. Federal-State Title V Block Grant Partnership Total</b>	27797405	29935366	27284801		29691458	

### A. Expenditures

Significant Variances -- Forms 3, 4, and 5 -- Budgeted vs. Expended

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure

narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

### Form 3

#### Program Income

Local family planning/reproductive health projects reported approximately \$3.17 million more than budgeted in Program Income - \$5,504,165 vs. \$8,521,802. This is a result of increased income earned by these agencies, who charge clients for services on the basis of a sliding fee scale. This significant increase reflects the ongoing rising costs of services and supplies, a larger number of clients served, and more thorough reporting. This large increase in Program Income has been the main factor in creating additional variances regarding Forms 4 and 5 as indicated below.

### Form 4

#### Pregnant

This variance, an increase of \$1,569,912 (89%), is due primarily to a \$1.01 million increase in Program Income, a \$111,000 increase in Match and a \$184,000 increase in Maintenance of Effort resources. Modest increases in Title V Local Aids and State Operations expenditures also contributed approximately \$165,000.

#### Other

This variance, an increase of \$1,017,274 (18.7%), is due primarily to a \$1.17 million increase in Program Income. This Program Income increase was slightly offset by minor decreases in Maintenance of Effort resources and Title V Local Aids expenditures.

#### Administration

This variance, an increase of \$105,264 (17%), is due to an error is due to an error in the 2009 Budgeted calculation. The cost of one position allocated to Administration was inadvertently omitted for the total. When this cost of \$49,546 is included, the total Budgeted Administration cost increases to \$672,629. The variance then becomes \$56,452 or only 8.4%.

### Form 5

#### Direct

This variance, an increase of \$2.7 million (21.6%), is due to an increase of \$2.7 million in the amount of Program Income provided by local Family Planning/Reproductive Health projects.

## B. Budget

The Title V MCH/CYSHCN Program anticipated award of \$10,658,234 is budgeted into two broad categories, State Operations and Local Aids.

Please see the attached file (Attachment V.B. - Budget) for full details.

***An attachment is included in this section. VB - Budget***

## **VI. Reporting Forms-General Information**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. Performance and Outcome Measure Detail Sheets**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. Glossary**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. Technical Note**

Please refer to Section IX of the Guidance.

## **X. Appendices and State Supporting documents**

### **A. Needs Assessment**

Please refer to Section II attachments, if provided.

### **B. All Reporting Forms**

Please refer to Forms 2-21 completed as part of the online application.

### **C. Organizational Charts and All Other State Supporting Documents**

Please refer to Section III, C "Organizational Structure".

### **D. Annual Report Data**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.